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ORIGINAL ARTICLES.

OUR POSTERITY.

The Address of the Retiring President before the Allegheny County Medical Society, April 19, 1887.

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The constitution of this Society makes it obligatory upon the retiring President to deliver an address on medicine or one of kindred topics. The subject of my address has been treated of before more ably than I could even hope to do; but the good results from frequent presentment of a subject will as surely follow as will the wearing of the granite stone follow the constant falling of raindrops upon it. The subject which I wish to present for your consideration to-day is

OUR POSTERITY.

The question, What shall we do to be saved? is just as pertinent a question now as it was two thousand years ago. My object principally, in this address, is to make a few remarks, briefly, bearing upon the laws of heredity, upon the great importance of proper selection, and upon a correct system of education of the people's physical, intellectual and moral powers.

It has been, I believe, truthfully asserted that in each generation, in all civilized countries, there have risen to the surface a few men who are the ideals of perfection, physically, intellectually and morally. If the ancestry of such men were traced, it would be found that they were the offspring of parents for several generations who presented just such qualities with which their descendants were endowed. Suppose A. was one of these ideal men; it is likely that his father and mother were persons above the average physical, intellectual and moral development, and that their parents were blessed with the same attributes. We have had many instances in our own country where an A. rose to a position of eminence, power and trust in which he exercised a mighty influence in church or in State, and justly so, by having inherited a good moral, intellectual, and physical development. It has also been noticed that his descendants have exercised the same influence for several generations, and then lost sight of entirely. It would seem to be adhering to the laws of heredity that like begets like, and therefore A.'s children, if he made proper selection, morally, intellectually and physically, would be on the ascending scale of development; and, other things being equal, would be stronger physically, intellectually and morally than their parents, and so on *ad infinitum*. And such would be a fact, but some of A.'s descendants make improper selection, and consequently their children fall below the plane of development of their parents; and once below this plane of development it requires many generations, even though proper selection were made, for the descendants who had thus fallen below A.'s plane of development to ascend again to that plane.

Suppose A. to have selected a wife whose plane of development, morally, intellectually and physically, was far below his own plane; it would follow that his children would be also below his plane of development, and so on indefinitely, or until A.'s posterity would become extinct, provided his descendants continued to make improper selections. Sometimes, however, a few of A.'s children, who inherit the constitutional development of the father, may possibly not descend below the father's plane of development, but his children and his grandchildren who inherit A.'s wife's inferior physical, intellectual and moral development will, according to the laws of heredity, descend below A.'s plane of development. The question might be asked: Would it be possible for any of A.'s descendants, who had thus fallen below his plane of development, to ascend again to the plane from which they had descended? I believe the answer to this question might be made truthfully in the affirmative; that is, if a wise vigilance was exercised in their selection. For example, suppose A. and B. (brothers), being both equal in moral, intellectual and physical development, should each make a selection—the former of C. and the latter of D. The plane of D.'s development is far below that of C.'s. The law of heredity would place B.'s children on a plane of development far below that of A.'s; and consequently, in order that B.'s children should rise to the plane of development of A.'s children, it would require many generations, even though wise selections were made.

An exception to the above law might be when B.'s children would inherit the constitution of the father, in which case some of B.'s posterity, through proper selection, might not be affected, but B.'s children who inherit the constitution of the mother would be the most affected, and would require the longest time, through proper selection, to ascend to the plane of development of A.'s children.

By our present custom of selection, there must

naturally be a sort of zigzag or shuttlecock scale of development—some families are on the ascending scale of development, whilst others are on the descending scale. Some of those families' descendants who are on the ascending scale may place their descendants on the descending scale by improper selection, whilst those on the descending scale may rescue a few of their descendants from such a scale of development by proper selection; but the posterity of many families who are placed thus on the descending scale of development are never rescued from such a scale of development by proper selection, but so continue along the downward scale of development till their posterity becomes extinct. So, too, occasionally along the ascending scale of development there may be found an offspring of weakly development; and, on the other hand, along the descending scale there may be found quite a perfect development physically, intellectually and morally; but on the latter scale of development there is more likely to be found a feeble body, possibly with a good development intellectually and morally.

There are many other causes besides improper selection which may place families and their descendants fon the downward scale of development, only a few ol which causes we have time at present to refer to, name y: acquired disease, our present system of education, together with the high-pressure education of women. I have taken it for granted that both acquired and hereditary diseases are the prime factors in the cause of the physical, the intellectual and the moral disability of those on the descending scale of development, and such should be avoided in selection.

Our present system of education has a tendency to develop the intellect at the expense of dwarfing the development of the body. We should have such a system of education as would develop simultaneously the physical, the intellectual and the moral powers of the child. Dr. Charles K. Mills says: "Education should be so arranged as to develop the brain by a natural process—not from within outward; not from the centre to the periphery; not from above downward—but as the nervous system itself develops in its evolution from a lower to a higher order of animals, from the simple to the more complex and more elaborate. Any system of education is wrong, and is calculated to weaken and worry an impressionable nervous system, which attempts to overturn or change this order of the progress of a true development of the brain. To develop the nervous system as it should be developed—slowly, naturally and ev enly—it must also be fed, rested and properly exercised." It might be added that the same scrupulous care as recommended by Dr. Mills in the development of the brain ought also to be exercised, at the same time and in the right direction, in the development of the moral and physical powers.

HIGH-PRESSURE EDUCATION OF WOMEN.

To be convinced of the fact that this high-pressure education of women will be conducive to weaken them as a class physically, and prevent them from being healthy mothers, and finally affect the health of their offspring, one need only open the door of any institution of high-pressure education of women, and there observe, too frequently, the pale faces, the sunken cheeks, the flat breasts, the wasp waists, and the stooped forms among many of its inmates. Even Napoleon, with his keen perceptive mind, nearly a century ago observed the evil tendency of high-pressure education of women; when he was asked the question, by a high-pressure educated French lady: who was the greatest woman then living? although the latter expected a different reply, Napoleon curtly answered: "The mother of the greatest number of children." A better reply would have been: the mother of the greatest number of healthy children. The first requisite to success in life, says Mr. Herbert Spencer, is to be a good animal, and to be a nation of good animals is the first condition to national prosperity. In order that children be good animals it is necessary for their mothers as well as their fathers to be good animals. A woman who throws herself in the current of competition either for higher literary honors, or in the professions, or in business, cannot for a long time remain a healthy animal, and therefore cannot be a healthy mother, and consequently cannot bear a healthy offspring. Hence Napoleon's reply to Madame De Stäel was correct, when he stated that a woman's proper sphere in life is to be a mother. If Napoleon's answer was correct—and we have no reason to doubt the correctness of the answer—then it follows that to be a mother is the proper sphere of woman, and any education that would lead a woman to be other than a healthy mother, will be not only detrimental to her own offspring, but will finally affect the offsprings of the nation. Dr. Emmet says that one effect of this higher education of women, of which we hear and read so much, will be to hinder those who would be good mothers of men from being mothers at all. In its full sense, says Herbert Spencer, the reproductive power means the power to bear a well developed infant, and to supply that infant with the natural food for the natural period. Most of the flat-chested girls who survive their high-pressure education are unable to do this. Were their fertility measured by the number of children they could rear without artificial aid they would prove unable to do this. It might be added parenthetically, that one effect of this higher education of women in this country is the increase of the number of nursing-bottles. It might be interesting to the advocates of such an education to know how rapidly the nursing-bottle is gaining admittance for use in families of America. According to a Paris letter, since his recent centenary celebration, M. Chevreul has received hundreds of letters from all parts of his country asking him for the secret of his strength, with minute inquiries as to what he eats and what he drinks; when he goes to bed and rises; how he exercises, and so on. To all these inquiries the old scientist replies through the Paris press that the secret of his long life consists of two words: "good health." For this gift he says he is indebted to his parents, for which he thanked them in the dedication of his works published in 1870.

The descendants of those now living in large cities will be ultimately placed on the descending scale of

development if they and their descendants continue to remain denizens thereof, for it has been said, and I believe observation bears out the truthfulness of the assertion, that if an embarriment were placed around a large city preventing healthy, robust recruits from the country, the inhabitants of such a city would become extinct before many generations.

In these times of such a craze for wealth, and power, and fame, the powers of the intellect are so pressed at the expense of the body that endurance ceases, causing in many wrecked constitutions, if not premature deaths. With such there should be called a halt, and less work and more recreation before it is too late, if they would prevent themselves and their posterity from being placed on the descending scale of development. The great importance of proper and wise selection in marriage should be indelibly impressed upon the young, soon to become fathers and mothers not only of this, but of all future generations, at the home firesides, at the schools of education, and from the pulpits. It is a question which is of vastly more interest and value to the American citizen, if he wishes to have transmitted to America's posterity America in the ascending scale of development, than all the mathematics and languages that might be taught in our schools of education, and all the dogmas and isms that might be proclaimed from our pulpits. Dr. Samuel D. Gross, shortly before his death, in an address at the dedication of the McDowell monument, after discussing the importance of skilful and successful laparotomy operations, skilful and successful operations for stone, and skill and success in other capital operations, said: "But the question of skill and success in capital operations sinks into insignificance compared with the great problem of the people's welfare." He further said: "The day has arrived when the people must be aroused to a deeper and a more earnest sense of the people's welfare, and suitable measures adopted for the protection as well as the better development of their physical, moral and intellectual powers. This is the great problem of the day, the question which you, as the representatives of the rising generation of physicians, should urge in season and out of season upon the attention of your fellow citizens; the question which alone and beyond all others should engage your most serious thoughts and elicit your most earnest coöperation."

Consequently, no father should suffer his son or his daughter to marry a person who could not present him with a satisfactory certificate from a competent physician as to the physical fitness of that person for marriage. No license should be granted by county or State officials to any individual without a like satisfactory certificate. In fact, the State Board of Health, in each State, composed of competent physicians, after careful examination, should issue such certificates to applicants. The family history of candidates for matrimony should be well studied by parties most interested, and by physicians granting such certificates. If more attention were paid to proper selection, and to a correct system of education of the people's physical, intellectual and moral powers, there would be no need for so many eleemosynary institutions, which are now dotted thickly all over our land; there would be fewer courts of justice needed, and consequently fewer prisons. Much suffering would be prevented; there would be happier homes, and in the end America would be populated by a more robust, a more intellectual, and a more noble people. By our present mode of selection, I might say, as I wrote on a kindred subject six years ago, that if it were not that every birth is a regeneration, and were the constitutional diseases which diseased parents transmit to their offspring not modified by an inalienable bequest of an older world, and by the redeeming instincts which our All-Mother grants to every new-born child on earth, the people of the world long ere this would have become extinct. Are we not aware of the fact that a powerful people once inhabited this fair land of ours, known as the Mound Builders? We do not know that the Indians, a powerful race, did inhabit this country in years gone by. Where are the Mound Builders now? and where is the Indian race? Then, since these two once powerful races have disappeared from our land, does it not behoove us to use all proper means, to throw out all possible safeguards that God and nature have placed in our hands, to preserve this great American people from eventually being placed on the descending scale of development, and consequently following in the footsteps of their predecessors, the Mound Builders and the Indian races?

THE GALVANIC CURRENT IN THE TREATMENT OF CERTAIN FORMS OF CATARACT.

Read before the Chicago Society of Ophthalmology and Otology, February 8, 1887,

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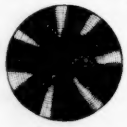
The following extract is from Erb's "Handbook of Electro-Therapeutics:" "Among diseases of the lens, cataract has been drawn recently into the field of electro-therapeutics. Neftel created no little excitement in the ophthalmological camp by a report of two cases of undoubted beginning cataract, in which all the symptoms of the cataract were relieved by methodical galvanic treatment, and visual power restored completely. After a sharp criticism of these statements by Hirschberg, Neftel acknowledged that the opacities of the lens, demonstrable with the ophthalmoscope, had not disappeared entirely, and explained the undoubted improvement of the eyesight to a removal of a molecular opacity, which was not recognizable upon ophthalmoscopic examination. He adds also that galvanic applications exert an influence, though not to any great extent, upon the opacities of ripe cataracts."

This subject is, therefore, still in its infancy, but its importance justifies further careful experiments, mainly with reference to beginning cataract. In 1879, or before, my attention was called to the use of electricity as a remedy for the treatment of cataract. The following case came under my observation:

Mrs. G., aged 53, consulted me for general debility, loss of vision, and catarrhal conjunctivitis. She had been in poor health for seven years, following the climacteric period. There was no evidence of organic disease of the viscera. Her family history was good, with the exception that one aunt, a brother and an older sister had cataract, the brother's cataract following an injury, not of the eye, but a fracture of both limbs; the sister's, at the age of 57 years, following an operation for fibroid tumor. One year before consulting me Mrs. G. had a severe attack of acute bronchitis, which left her greatly debilitated, and from which she had not fully recovered. Right eye, vision equals Snellen No. 8, at 12 inches with correcting glass; left eye, vision equals Snellen No. 5, at 12 inches with correcting glass. Two months before she was able to read with the left eye and thread a needle. The right eye had been out of use for some time, and had been slightly irritated and "weeping." Examination with the oblique illumination gave the results indicated in the following diagram:

No. 1.

As she had for a long time been under the careful management of a good practitioner, and the whole range of tonics and stimulants had been exhausted, I concluded to try central galvanization, as recommended by Beard and Rockwell in their first edition. To my great satisfaction my patient responded to the treatment, and in three months had gained fifteen pounds in flesh and greatly in general vigor. While attending to another member of the family I found my former patient reading, and much to my astonishment found it to be Milton's Paradise Lost, in small print. I again made an examination of the eye under atropine, with the oblique illumination, giving the results as in sketch No. 2.



No. 2.

Soon after this case had passed from my observation my attention was called to the papers of Neftel and others, with the discussion. This and the doubt that these papers engendered, has tended to make me slow in giving to the profession the results of my limited experience and study in the treatment of incipient cataract by the use of the galvanic current of electricity. I doubt if I should have done so now, but for reasons which I cannot here mention, and to prevent being misunderstood by my professional friends and associates. The following are the cases as taken from my notes. I have arranged my cases in the following groups:

Group 1 includes those cases in which there was no improvement, as follows:

Case 1.—1881. Mrs. La L., aged 49. R. V. = $\frac{15}{60}$, L. V. = $\frac{15}{100}$. Peripheral cataract both eyes. Long narrow spikes extending to centre of lenses, no nebulæ. No change in vision for two years. Previous health good. Three years previous had fracture of right arm and amputation of hand at wrist. Treated one month, fifteen sittings, no improvement. Recent letter from son states that, one year ago, glaucoma developed in right eye.

Case 2.—Mrs. K., aged 53. R. V. = 20, L. V. = $\frac{20}{60}$. Right eye + $\frac{1}{10}$ reading V. = Snellen No. 8. Left eye + $\frac{1}{10}$ V. = Snellen No. 3. Peripheral cataract. Many long spikes in both lenses, no nebulæ. Occasional sittings for two and a half months. No improvement. Lately successfully operated.

Case 3.—1883. Mr. H., aged 54. R. V. = $\frac{20}{60}$. L. V. = $\frac{20}{40}$. Peripheral cataract. Two long spikes and many short ones in each lens, also what seems to be a calcareous deposit at the periphera of lenses, much nebular matter. Has atheromatous degeneration of arteries and valvular heart-lesions. Could get no definite results with the ophthalmoscope. Treated six weeks, eighteen sittings. R. V. = $\frac{20}{20}$. L. V. = $\frac{20}{40}$. Six months later R. V. = $\frac{20}{100}$, L. V. = $\frac{20}{60}$.

Group 2 includes cases that have been under observation from four to seven years, in which the improvement has been permanent.

Case 1.—1879. Mrs. McC., aged 50. R. V. = $\frac{15}{100}$, L.V. = $\frac{15}{60}$. Peripheral cataract. Dense nebulæ about lines. Vision had diminished slowly for past 4 months, following carbuncle of the neck; in other respects health good. Under treatment two months, R. V. = $\frac{20}{30}$., L. V. = $\frac{20}{20}$. Six and one-half years later there was no perceptible loss of vision.

Case 2.—1880. Mrs. G., aged 52. R. V. = $\frac{15}{40}$, L. V. = $\frac{15}{60}$. Peripheral cataract. A few short lines and nebulæ extending far toward centre of lenses. Vision had diminished rapidly for two months. Had noticed "weeping" in left eye for six months. Nine months previously had pneumonia. Treated two months, R. V. = $\frac{15}{30}$, L. V. = $\frac{15}{15}$. Extensive spot of choroidal atrophy just at junction of right and left lower field, near ciliary region. Four years later reported no loss of vision.

Case 3.—1880. Mrs. L., aged 57. R. V. = $\frac{20}{60}$, L. V. = $\frac{20}{100}$. L. V. with reading correction + $\frac{1}{10}$ = Snellen No. 10. Peripheral cataract. Long lines and dense nebulæ. Has been in poor health for past four months. First noticed loss of vision two months ago. Under treatment four months, forty sittings, R. V. = $\frac{20}{80}$, L. V. = $\frac{20}{60}$. With correction reading vision equals No. 3, Snellen. Eighteen months later, vision and health improved.

Case 4.—1881. Mr. D., aged 63. R. V. = $\frac{15}{100}$, L. V. = $\frac{15}{200}$. Peripheral cataract. Three long lines and many short ones, with dense nebulæ in each lens. Cannot read with correcting glasses. No change in vision for six months previous. In better health than during preceding winter. Treated two months, R. V. = $\frac{15}{40}$, L. V. = $\frac{15}{100}$. Can read with correcting glasses. Two years later, no perceptible change in vision.

Case 5.—1883. Mrs. B., aged 70. R. V. = $\frac{15}{100}$, L. V. = $\frac{15}{80}$. Left eye with correction reading vi-

sion equals No. 5, Snellen. Right eye, two long lines meeting at centre of lens form a V, and many short lines, all the lines surrounded by nebulæ, more or less dense; left eye, one long line and many short ones. Had malarial fever nine months previously, three months after recovery noticed disturbance in eyes, which was followed shortly by loss of vision. Treated four months, R. V. = $\frac{15}{30}$, L. V. = $\frac{15}{20}$. With correcting glasses reads Snellen, No. 1; can thread a fine needle and do fine sewing.

Case 6.—1883. Mr. H., aged 54. R. V. = $\frac{20}{80}$, L. V. = $\frac{20}{100}$. Could not read with glasses. Peripheral cataract, more marked in left eye than in right. Was examined in January, 1883 (six months previous), with diagnosis of cataract in left eye. Had malarial fever in March, and when convalescing noticed failure of vision in right eye. Under treatment three months, thirty sittings, R. V. = $\frac{20}{200}$, L. V. = $\frac{20}{100}$. Four years later, R. V. = $\frac{20}{90}$, L. V. = $\frac{20}{100}$.

Group 3 includes cases in which there has been complete removal of short lines and nebulæ.

Case 1.—1881. Mr. J. L., aged 49. R. V. = $\frac{20}{40}$, L. V. = $\frac{20}{30}$. Correcting lens for reading + $\frac{1}{8}$. Peripheral cataract in both eyes. Right eye, three long spikes reaching nearly to centre of lens and surrounded by dense nebulæ. Left eye, one long spike reaching to centre of lens, and many short ones; slight nebulæ. General health fair; lately developed large varicose ulcer. Two and one-half months under treatment, twenty-three sittings, V. = $\frac{20}{20}$ in both eyes, with + $\frac{1}{12}$ correction reads Snellen, No. 1. Two and one-half years later there was no change in vision.

Case 2.—1883. Mr. L., aged 54. R. V. $\frac{15}{40}$, L. V. $\frac{15}{15}$. Short lines and nebulæ in both lenses; much depressed from loss of property; has labored hard for last four years. Regular daily treatment for three weeks and occasional treatments for two months; at end of two months no lines and no nebulæ visible. Vision normal in both eyes. Two and one-half years later, stronger correcting glasses gave normal vision. No sign of degeneration of lens.

Case 3.—1883. Mrs. B., aged 63. R. V. = $\frac{20}{20}$, L. V. = $\frac{20}{30}$. With correcting glass reads Snellen, No. 2. Had noticed loss of vision R. E. after protracted confinement to house, from injury, L. E., following chicken-pox. After daily treatment for three weeks, could see no lines nor nebulæ in left eye; in the right eye nebulæ had cleared, leaving lines unchanged. Four years later no appreciable change in either eye.

Group 4.—Recent cases in which there has been complete absorption of opacities.

Case 1.—June, 1886. Mrs. M., aged 63. R. and L. V. $\frac{20}{20}$. Reading vision, with + $\frac{1}{8}$ correction, equals Snellen, No. 8. Peripheral cataract both eyes. Consulted for excessive lachrymation, and rapid change of glasses, being able to read but a short time. Three months previously had consulted Dr. ———, who also had diagnosticated cataract. Treated one month, ten sittings, R. and L. V. = $\frac{20}{20}$. No lines nor nebulæ visible; reads Snellen, No. 1, with + $\frac{1}{14}$ correction. Nine months, vision equals $\frac{20}{20}$, and no sign of opacities.

Case 2.—July, 1886. Mrs. F., aged 68. Myopic. R. V. = $\frac{20}{100}$, L. V. = $\frac{20}{200}$. Reading glasses, R. + $\frac{1}{18}$, L. + $\frac{1}{22}$. Slight cataractous radii in both lenses. Has much trouble from loss of sleep, uses chloral at times. Under treatment one month, twenty-four treatments, only one or two lines visible at end of treatment. November, 1886, fully recovered; can see no lines nor nebulæ.

In all cases in which I have suggested galvanism as a possible remedy, I have steadily avoided encouragement as to the result, and had it fully understood that the remedy was on trial; though I had long considered it a legitimate treatment. In my first cases I did not make the discrimination that Wells offers as to the rapidity or stasis of development of catatact, for I had not learned to fully measure the change that was producd in conjunction with improvement of vision. It was soon manifest that the great change which took place was not in the already degenerated lens structure, but in that portion which was in a metamorphosic state, *i.e.*, the nebulæ that enveloped the lines and filled the more transparent portion of the lens; this nebular matter is slowly absorbed, leaving the former gray portions of the lens clear and transparent, and the lines clearly marked. I have never seen radii that were already fully degenerated, become absorbed or changed more than could be accounted for by the clearing of the nebulæ. In those cases where we would expect arrested development, there was absolutely no change nor improvement of vision, except in one case; and that was due alone to the improvement of the choroid and retina.

As to the etiology of cataract or opacities of the lens, there can be but one opinion; that it is the disturbance of nutrition, through functional and organic changes in the uveal tract, nerve and retina, and that these changes may be associated with, and are usually due to, some general disturbance of nutrition. In thirty-one cases which I have tabulated from my private work, and twenty-six from my outside or dispensary practice, I have found in more than 90 per cent. of the cases that there was a history of acute disease or an acute exacerbation of a chronic disease, or an exhausting mental depression or depression preceding the disturbance of vision, and in many cases attributed to it by the patients. In thirty per cent. of the cases there was evidence of choroidal degeneration, neuro-retinitis or retinal atrophy; showing that it was not the lens alone that had been or was suffering from disease. Wells says: "It appears most probable that the causes of the loss of transparency of the lens are to be sought in the impairment of nutrition, due to some morbid alterations in the vitreous humor and inflammatory changes in the lens itself."

The therapeutic action of electricity is threefold: Mechanical, tonic, and catalytic. We have to deal in this connection only with its tonic and catalytic actions. It is tonic from its action on the pneumogastric and sympathetic; catalytic from its electrolytic action, as manifested by the rapid changing of the nebula long preceding the manifest results in the general system.

Beard and Rockwell say: "Indirect constitutional effects result from localized electrization of nervous centres, especially from galvanization of the brain, spinal cord and sympathetic of the cervical region." The physical effects of electricity passing through the body, are heat, transference of substances from one pole to the other, and modification of endosmo sis and exosmosis. In the structural changes which take place, we have the effects of the catalytic or chemical most markedly manifested. Electrolysis of organic substance starts a process that continues long after the current has ceased to flow. Dr. F. H. Martin, in his paper on "Electricity in Gynecology," page 10, says: "I have worked on the principles enlarged upon in the first part of this paper, viz.: 1. That a galvanic current of moderate quantity, passed through a soft tissue of the body, produces electrolytic action all along its course. 2. That a process of rapid absorption is produced in the parts so acted upon. 3. That normal tissues, while the least susceptible to the current, and therefore least liable to be chemically decomposed, are, if decomposed and absorbed, almost immediately replaced by the inherent property of healthy tissue to reproduce itself. 4. That pathological tissue is usually of lower vitality than normal tissue, is more easily decomposed by the current, and when it is decomposed and its absorption accomplished, it has not the power to reproduce itself."

By one who has used electricity in general practice and noted the continuous improvement of patients months after the treatment has been discontinued, it can readily be understood why frequent séances are not required in a large majority of cases.

My experience would lead me to associate the improvement in vision directly with the visible local changes. If the cataract is due to the disturbance of nutrition or change in the vascular supply, and in a large number of cases preceded by a marked disturbance of the general health, is it not fair to suppose that in those cases cited by Bull and others, where there is arrested development, delayed maturing or spontaneous absorption, that the cause for the change may lie in the improvement of nutrition? That the remedy fails in a certain percentage of the cases, or in fact all the cases under treatment, may not be the fault of the remedy, but in the selection of the cases to be treated. *In all cases in which the disease is progressive*, as indicated by the fat granules and nebula, where electricity is well borne, where the choroid and retina are not greatly degenerated, and where there are no complications of cirrhosis of kidneys or liver, diabetes or organic disease of the heart or lungs, *improvement may be expected.* The cases in which improvement is not to be expected are those in which vision has remained stationary for some time, and where there are structural changes in the choroid and retina. The opacities of the lens treated by me with electricity, are of the senile forms of cataract, commencing at the periphera and extending towards the centre in the shape of radiating lines or spikes. In the progressive form the lines are surrounded by, and the inter-space more or less filled with, an aggregation of dots and nebula of gray matter. In one case there was marked yellow deposit under the anterior capsule.

The battery to be used should consist of a number of medium sized cells, giving a steady, constant current. The special battery manufactured by McIntosh & Co., or the battery invented by Felton, I think are the best adapted to this purpose.

The treatment may be given in this way: The electrode should be first freely moistened; the negative placed over the eye, the positive at the nape of the neck, at the angle of the jaw or over the stomach. Three or four cells should first be turned into the circuit, followed by one, two, three or four more, until a slight vertigo is experienced, then gradually reducing the number of cells; the whole sitting not occupying more than five to ten minutes. The treatment may be at first given daily, and gradually decreasing to once or twice a week. In some cases I have been obliged to use a very mild current, and in others as high as eighteen elements, and in a few cases the galvanic current was not well borne at first, but a few daily treatments with the induced current rendered my patient less susceptible or sensitive, and I was enabled to use the galvanic current with good results.

PERINEPHRITIC ABSCESS; OPERATION; RECOVERY.

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(FORMERLY OF WELLESLEY, MASS.)

FELLOW OF THE MASSACHUSETTS MEDICAL SOCIETY; MEMBER OF THE AMERICAN MEDICAL ASSOCIATION; MEMBER OF THE GYNÆCOLOGICAL SOCIETY OF BOSTON, ETC.

Acute inflammation resulting in suppuration in the connective tissue surrounding the kidney must be a rare disease. The literature in the medical journals is exceedingly scant, and but brief mention is made of the affection in the books. Yet we can hardly expect it to be infrequent when we consider its etiology. Injury is supposed to be the most frequent cause; next, exposure to cold, which is questioned by some, but undoubtedly is a cause; previous suppurative nephritis or pyelitis; extension of pelvic cellulitis; operations on the rectum; inflammatory affections about the bladder; psoas abscess; typhlitis and perityphlitis. Well authenticated cases have been reported in children, although by some this has been denied.

The symptoms are said to be local pain, shooting downwards; chilliness, followed by fever; malaise; nausea; anorexia; coated tongue; rigors and profuse sweats; emaciation; obstinate constipation. Deep-seated fluctuation may be detected, but it may be very late. There may be a tumor, but that may appear very late. Pus usually points in the lumbar region, or it may rupture into the bowel, or into the peritoneal cavity, in which case death would soon follow, unless the condition was early diagnosticated and abdominal section resorted to at once.

The differential diagnosis is to be made from hydronephrosis; from echinococcus; from cancer; and from pyelitis with pyonephrosis. In the early stages the diagnosis is extremely difficult, especially in children;

and by good authority is pronounced impossible in the absence of a tumor. My experience with this disease is limited to a single case, and its history, difficult diagnosis, course and termination seem to be worthy of a pretty full record, and especially so as but a very few cases can be found to which more than a passing notice is given.

Miss P., of Massachusetts, aged about 30 years, was first seen by me as a patient on August 28, 1883. She was a tall, spare brunette, and had always had fairly good health. She had been ill several days before I was called. Nearly a week before she had been on an ocean excursion, had been in the ocean bathing and was chilled at the time—came home and was taken ill. There is a constant dull pain, uninfluenced by motion or position, in the upper part of the right lumbar region, and inclined to the front. Slight tenderness over this region and extending over the abdomen. Bowels quite regular. Marked anorexia. Tongue coated white. Slight nausea; no vomiting; no urinary symptoms; no chills. Menses have been regular and normal. Pulse 100; temperature 101° F. Patient sits up part of the time.

August 29. Bowels moved by a cathartic to-day. All the symptoms the same.

September 1. Side more tender and painful, requiring an opiate. Anorexia is a marked symptom. Pulse 100; temp. 99.5° F.

September 4. Not as well. Pain shooting down right thigh, and there is some tenderness in the right groin. Anorexia. Pulse 100; temp. 101°.

September 6. Menstruating at regular time. Despondent; tired. There is less pain, no opiate required. Anorexia marked. Tenderness still a prominent feature over the right side and in the right groin; no swelling anywhere. Pulse 80; temp. 100.5° F.

September 7. Less tenderness of abdomen—otherways the same. Pulse 88; temp. 101.8° F. As I was to be absent from town for a few days, I placed the patient under the care of my neighbor, Dr. G. J. Townsend.

September 12. I resumed charge of the case again. Tongue cleaner and patient appears some better generally. There is some pain complained of in the right hip. She cannot walk well on account of the pain in the hip. Less pain in the side. Sweats profusely and complains of weakness; anorexia still marked. Pulse 80; temp. 100° F.

September 14. Slight icterus, more prominent about face and neck than elsewhere. Tenderness over side and abdomen; pain in right hip when walking. Pulse 80; temp. 100° F.

September 17. Patient still sits up part of the time. Tongue quite clean and moist, but anorexia as marked as ever. Skin less yellow; tenderness of right side and abdomen still prominent; pain in the hip on motion; sweats profusely nights. Afternoon pulse 100; temp. 102° F.

September 21. Slight chill last night for the first time. Pain in the hip and groin. No swelling could be found. Bowels moved quite regularly. Pulse 90; temp. 101° F.

September 25. Pain in the hip is constant—she says it is "inside the hip." Pulse 100; temp. 100.1° F.

September 27. One month after my first visit patient rode out, it being a pleasant day; she thinks she feels better for it. Pain in hip some less. Pulse 90; temp. 100.5° F.

September 30. In addition to the other symptoms the right thigh is beginning to be flexed, and cannot be fully extended. There is more tenderness over the right kidney, and I think some little fulness in that region. Up to this time no satisfactory diagnosis has been made. My notes at this time read: "Abscess? malignant disease? tumor? floating kidney? What?

October 2. A consultation was held with a gentleman of large experience, and the physician who officiated at the birth of the patient. A careful examination was made, and the following symptoms summed up in their order of prominence: 1. A long-continued, persistent anorexia. 2. Tenderness in the right lumbar region, first extending over a greater part of the abdomen, later becoming more marked over the right kidney, with some fulness in that location, accompanied by a constant dull pain in the right hip and groin, and flexion of the thigh. 3. Fluctuating, low, but persistent fever, accompanied with but one or two very slight chills, but with profuse perspiration at times. 4. Emaciation quite marked. The urine, which has been free and without abnormal qualities before, is now three pints in quantity in twenty-four hours, S. G. 10.20, contains a trace of albumen, a small amount of pus and a few epithelial casts. Diagnosis hinges between deep-seated abscess and malignant disease, the consultant inclining to the latter, as I perhaps would have done had I not watched the case carefully from day to day. Prognosis guarded. Treatment continued, namely: opiates sufficient to relieve pain, with quinia in tonic doses, and all the nourishment she could be made to take, with some alcoholic stimulants.

October 3. Much pain in the hip, with a "twinge" down the limb at times, a spot over the right kidney very tender. Pulse 104; temp. 102.1° F.

October 4. Pulse 112; temp. 103.5° F.; other symptoms the same.

October 5. Patient looks haggard—is restless; asks if she can get well; cannot lie on left side, decubitus mostly dorsal with limbs drawn up. Vomited once this morning. Pulse 91; temp. 101.6° F.

October 7. Had a restless day yesterday; perspires profusely when asleep. Is taking many eggs for nourishment, which are forced. Pulse 100; temp. 100° F.

October 8. Much pain caused by defecation, which is assisted by enemas. Bowels tender and somewhat tympanitic. Pulse 96; temp. 101° F.

October 9. Has a sharp pain in the right lumbar region; cannot lie on the right side on account of a pulling sensation. Pulse 88; temp. 101.8° F.

October 10. Slight puffy appearance about face and eyes noticed for the first time, but urine is free. Slight chill yesterday, followed by flushed face; seems dull and low-spirited. Pulse 104; temp. 102° F.

October 11. Perspires much of the time; tongue clean and red; anorexia as prominent as ever. The

fulness over right kidney is decidedly more prominent and very tender, but I can get no fluctuation. Percussion flat. Less pain in the hip, but requires opiates. Pulse 101; temp. 101° F. A large flaxseed poultice was applied over right kidney.

October 13. Consultation was again held. Night sweats are profuse. The enlargement over right kidney is more pronounced, but fluctuation could not be obtained. Pulse 95; temp. 103° F.

At this point I suggested aspiration, but the consultant was in favor of waiting, and was inclined to the diagnosis of very serious if not malignant disease of the kidney, and a grave prognosis. We agreed to wait a few days longer before resorting to surgical measures.

October 14. I can get a slight wave of fluctuation, and am more convinced than ever that there is deep-seated pus. Patient very tired; there is considerable pain. Pulse 105; temp. 103.9° F.

October 15. Forty-eight days since my first visit. Consultation again—patient much the same as yesterday. Fluctuation being evident, it was decided to explore the tumor, which was now quite prominent over the right kidney. Patient was etherized, and I passed an aspirator needle well into the swelling and obtained pus; it was too thick to be evacuated through the aspirator, and I withdrew the needle, made a longitudinal incision over the most prominent part of the swelling, dissected carefully down about one and a half inches and came to the sac, then passing in a director made a free opening, and evacuated about eight ounces of pus. A drainage-tube was inserted and the opening dressed as near antiseptically as the circumstances and surroundings would permit. Patient rallied from ether well, but was very weak.

October 16. Comfortable, but weak. An enormous amount of pus has been discharged. Pulse 110; temp. 102°. The cavity was well syringed out with a 1–40 solution of carbolic acid, and the opening redressed as before.

October 17. Pus discharging very freely; patient quite comfortable. Pulse 100; temp. 99.6° F. Opening dressed with oakum.

October 18. Some diarrhœa; abscess discharging freely. Pulse 92; temp. 100° F. Redressed as before.

October 19. Discharge of pus diminishing. Diarrhœa checked with bismuth and morphia. Thigh can be extended to full extent. Syringed cavity and redressed with oakum.

October 27. Since last note patient has been doing well. Abscess has discharged a large amount, but discharge is now growing less. Opening has been syringed daily and dressed with oakum. Patient's strength has been well sustained on iron and quinine in tonic doses, with all the liquid nourishment she could bear. Last night had a chill—cause obscure. Pulse 120; temp. 103.2°. A larger drainage tube was inserted, cavity thoroughly syringed out with carbolized solution, 1–40. In the afternoon a consultation was again held, but no cause of the chill was apparent. The pulse had fallen to 100 since morning, and temp. to 101.8° F.

October 28. A slight erysipelatous blush was present around the opening, which undoubtedly accounted for the chill and rise of temperature and pulse. Pulse 116; temp. 102° F. Opening syringed as before, and dressed with a lead and opium solution carbolized.

October 30. Erysipelatous blush gone, abscess discharging but little; cavity much smaller. Pulse 100; temp. 99.5° F.

November 3. Very slight chill this morning; abscess redressed. Pulse 100; temp. 100° F.

November 4. Pulse 80; temp. 98.8°. Very little discharge.

November 7. Drainage-tube removed. Patient improving fast.

November 13. Slight discharge yet. Patient sits up some of the time. Pulse 80; temp. 98.5° F.

November 23. Opening completely closed. Patient discharged well, nearly three months from my first visit. I have no doubt that the chill and erysipelatous blush were due to a want of asepsis, and although it did not prove a very great obstacle to overcome, a greater neglect might have proved disastrous.

IMMOBILIZATION IN HIP-JOINT DISEASES.

BY B. M. GRIFFITH, M.D.,
OF SPRINGFIELD, ILL.

Mr. A. A. B., aged 32 years, Canadian parentage, about four years ago received a severe fall upon the right hip when alighting from a moving train. To all appearances he soon recovered from the immediate effects of this injury, About two years afterwards his hip-joint commenced paining him upon excessive exercise or fatiguing use of the limb, and in the course of another year he complained of pain in the knee-joint. This was the history of the case when I first saw it in August, 1886. The right limb was apparently three-fourths of an inch longer than its fellow, and the right foot slightly everted. He complained of excessive fatigue in the joint on walking, especially if the ground was rough, and if he accidentally stubbed his toe the pain in the joint was quite severe. Upon sneezing, he would instinctly seize the affected limb in order to lessen the pain caused thereby.

No hereditary taint was discovered by examination of the patient's history. The general health was quite good. On manipulating the limb, the hip-joint was found rather sensitive; inversion limited. When lying on his back the patient was unable to place the heel of his right foot on the toes of his left; the pelvis was also tipped considerably, and the pain was quite marked when the limbs were fully extended in this position. The pain was lessened by flexing the thigh on the abdomen at an angle of about twenty degrees, and slightly everting the foot; and by so doing placing the pelvis flat on the floor. At no time was pain produced by striking the heel of the foot while the limb was extended.

The plan of treatment entered on was one suggested to the patient by Dr. Alfred Bray, of Minneapolis, Minn., *i.e.*, the application of a plaster of-Paris cast to the pelvis, and thereby immobilizing

the joint. The cast was applied as far up the body as the xiphoid cartilage, and extended down the affected limb to the knee, making it especially strong on the groin. The cast was applied by having the patient stand on a stool, with the limb slightly everted and somewhat advanced, thereby placing the limb in a comfortable position. The patient was afterwards placed on a canvas cot, and a double inclined plane and a slight weight used. In this position he was entirely comfortable, and commenced improving from the start, cod-liver oil and comp. syrup wheat phosphates being the only medication.

Patient was kept on the cot for twelve weeks, when the cast was removed. He complained terribly of muscular soreness for several days. The limb can now be moved in all directions, flexion and adduction being slightly compromised. No pain in either knee- or hip-joints. The movements, while slightly limited, are more powerful than formerly, and are getting stronger. The pelvis is also improved in position. It has been four months since the cast was removed, and neither pain nor any of the old sensations have been felt in the joints; and the patient walks with an almost imperceptible limp, while he was very lame before the treatment.

This case I offer as an illustration of the most effective method of treating hip-joint troubles when seen under such conditions, believing it to be more efficacious than the use of braces.

235 S. 5th Street.

MEDICAL PROGRESS.

Antiseptic Midwifery.—In a report by Dr. K. Inoieffs of the work done in the Lying in Institution in connection with the Golitsinski Hospital, in Moscow, for the year 1886, the advantage of antiseptic midwifery, which is strictly carried out there, is evident, as out of 541 cases there were but two deaths. Some of the statistics, which are very carefully kept, may be of interest. The largest number of births occurred, as it is popularly believed they do, at night, 145 taking place between midnight and 6 A.M.; the numbers corresponding to the remaining three-quarters of the twenty-four hours being 131 from 6 A.M. to noon, 107 from noon to 6 P.M., and 144 from 6 P.M. to midnight. There were fourteen abortions and nine cases of twins; three births took place in the street. Of the remaining 501, 478 were vertex presentations, fifteen breach, and eight transverse. In nine of the fourteen cases of abortion the ovum was removed mechanically. When there was considerable hæmorrhage and the os was not dilated, a hot vaginal injection of carbolized water was given which was, as a rule, successful. Twice, a plug consisting of a long strip of cotton-wool moistened with glycerine and iodoform was introduced by means of the speculum, as much as possible being inserted into the cervical canal, and subsequently, when the os was sufficiently patent, the finger was introduced and the uterine contents removed. In one case there was a slight amount of perimetritis, and in two a single rise of temperature. In one case a spatula was cautiously used to assist the irrigation, and once the contents were removed with the help of a sharp hook. Apart from cases of placenta prævia and abortion, there were twenty-nine cases of hæmorrhage, six of these occurring in primiparæ; six took place during the first and second stages of labor, the rest in the third stage and post-partum. The treatment adopted was, during the first stage, to plug, and when the os was sufficiently dilated to rupture the membranes. If there was rigidity of the os, narcotics were given. When uterine atony was the cause, massage, the application of ether to the abdomen, hot injections, and (after the birth of the placenta) ergot was resorted to. As to operations, episiotomy, or a double V-shaped incision of the perineum was performed five times, no sutures being inserted afterwards. Twice the os uteri was incised; twice the prolapsed cord was replaced; perineal sutures were required in twenty cases. In the performance of the operation the most careful antiseptic precautions were taken; in sixteen cases the union was complete. Retention of membranes required the introduction of the hand into the uterus once, but in fourteen cases the placenta had to be artificially extracted, being completely adherent once, and partially so thirteen times. Labor was induced permaturely for contracted pelvis three times, twice by the injection of water at 28° R. (95° F.) through a tube passed into the cavity of the uterus, between the uterine wall and the fœtal membranes; in the third case it was induced by the introduction of an elastic sound into the uterus. Podalic version was performed eleven times, and the forceps applied fifteen times. Craniotomy was performed twice.—*Lancet*, May 7, 1887.

Physiological Action of Spigelia.—Dr. H. A. Haré, of the University of Pennsylvania, in a study of physiological action of spigelia, or pink-root, says: On the cardiac muscle it acts as a direct depressant poison, for if it be injected into the jugular vein in such a way as to come suddenly in direct contact with the heart the movements of that viscus almost instantly cease. Further than this, if the excised heart of the frog is dropped into a strong solution of the drug its movements are almost immediately stopped in a condition of diastolic arrest, although the relaxation is not very marked. When a frog receives as much as twenty minims of the extract of spigelia, the heart is slowed to a considerable extent, as much as ten or fifteen beats per minute, and diastole, while not increased in length, is nevertheless very full and marked. The change from systole to diastole is abnormally rapid, so that the heart in one moment in systole springs with a quick movement to its full diastolic condition. Systole, however, gradually increases on diastole, in much the same manner as in digitalis poisoning, until finally the greater portion of the ventricle fails to dilate, the apex being tilted more and more forward while the ventricular walls are powerfully contracted. As the systolic pauses increase, the diastolic movements decrease in volume, until finally the heart dilates no more than it does

normally. At this time the powerful and heretofore spreading systolic contractions seem to lose power and the heart shortly stops all movement in a semi-relaxed state. Experiments on the warm-blooded animal show that on the injection of one drachm, or less, of the drug, the action of the heart is very rapidly slowed in its movements, and that this slowing is chiefly due to central inhibitory stimulation is shown by the fact, that if the vagi be cut before the drug is given this slowing does not occur, and also if after the drug has slowed the heart the vagi be cut, the inhibition no longer remains. That the fall of arterial pressure produced by this drug is due in great part to the cardiac depression which it produces is proved, since asphyxia will cause a rise in pressure, and that the pressure returns nearly to normal as soon as the heart gets rid of the drug which has been suddenly injected into it. On the respiratory centre the drug seems to have a still more depressing influence, respiration ceasing some moments before the cardiac arrest.—*Medical News*, March 12, 1887.

LIGATURE OF THE EXTERNAL CAROTID ARTERY.—In a paper describing three cases of ligature of the external carotid artery, in two of which both vessels were tied simultaneously, DR. JOSEPH D. BRYANT draws the following conclusions:

1. Ligature of the external carotid artery, together with dependent ligature of the branches arising from the first inch of its course, is a safe and commendable operation.

2. When the facial and lingual arteries do not arise singly, or by a common trunk from the first inch of the course of the external carotid, the branches arising at the point of bifurcation of the common carotid should be tied.

3. Simultaneous ligature of both external carotids is a rational preparatory measure for operations involving the parts supplied by their branches when dangerous hæmorrhage is feared. If the pharynx be involved, the ascending pharyngeal branches should be ligatured also.

4. Simultaneous ligature is advisable as a final expedient to diminish the rapidity of the development of extensive malignant growths when they are nourished by the branches of the external carotids.

5. Ligature of one or both of the external carotids for the cure of aneurismal formations of the branches of the same is not feasible as an independent curative measure.

6. Ligature of the common carotid should not be done for the cure or for the arrest of morbid conditions involving the external carotid or its branches, except as a final resort.—*Medical News*, May 14, 1887.

CARBOLATE OF MERCURY IN SYPHILIS.—DR. KARL SHADEK, of Kieff, being anxious to try the effects of carbolate of mercury, which has been strongly recommended in syphilis by Professor Gamberini, requested M. H. Brandt, a pharmacist in Kieff, to prepare some for clinical use. This he did by precipitating a very dilute solution of bichloride of mercury with a concentrated alcoholic solution of carbolate of potassium. A yellowish precipitate was obtained, which, after being frequently agitated with the liquid for twenty-four hours, assumed a whitish appearance. It was filtered and washed with distilled water till the washings showed no traces of chloride. It was then transferred to a fresh filter paper and dried under a bell jar. In this way a nearly white tasteless amorphous substance was obtained, which was scarcely acted upon or dissolved by cold, but was readily soluble in boiling, hydrochloric acid. The name given to it by Dr. Shadek is "hydrargyrum carbolicum oxydatum," and he has been using it in his private practice for several months. At first he gave it in the form of pills, one of which, containing about an eighth of a grain, was ordered three, or occasionally four times a day. It was well borne, and did not interfere with the digestion. In some cases the treatment was continued for six or eight weeks, without producing colic or other disagreeable symptoms. The total number of syphilitic cases in which it was given internally was thirty-five (twenty-six men, six women and three young children). In five of these there was swelling of the gums and salivation. Mercury was found in the urine after the third dose. Its therapeutic value was especially remarkable in macular and tubercular syphilides and in syphilitic psoriasis of the palm and the sole. Syphilitic rash and slight relapsing forms yielded to the treatment in from two to four weeks; in syphilitic affections of the mucous membrane, and in papular and pustular eruptions, from four to six weeks were required. Multiple enlargements of glands were but little affected by it. In the case of children from 2 to 4 years old, doses of about the fifteenth of a grain were well borne twice daily.—*Lancet*, May 7, 1887.

TRANSPARITONEAL NEPHRECTOMY.—At a recent meeting of the Paris Surgical Society, M. TERRIER communicated a note on a new method of performing transperitoneal nephrectomy. The abdomen is opened in the middle line, and the intestine pushed aside so as to uncover the peritoneal membrane covering the kidney. A verticle incision is then made in the membrane, the edges of which are held back with clamps. After removal of the tumor, the pedicle and the ureter are tied and brought forward through the peritoneal incision to the abdominal wound, where they are secured. In this manner the peritoneal cavity is closed on all sides. M. Terrier claims that this operation does not necessitate drainage through the loin, as has generally been supposed. *British Medical Journal*, May 7, 1887.

XYLOL IN SMALL-POX.—OTVOES has used xylol in 315 cases of small-pox with excellent results. This substance is recommended by Zuelza as an antiseptic; it coagulates albumen. Otvoes administered it in wine, in doses of 2 to 3 grammes a day. The total amount given was sometimes 24 grammes. Otvoes gives the following formula for the administration of xylol: ℞. Pure xylol, 3 grammes; menthol water, distilled water, āā 50 grammes; cinnamon syrup, 10 grammes. One spoonful every two hours. *British Medical Journal*, May 7, 1887.

THE
Journal of the American Medical Association.
PUBLISHED WEEKLY.

THE EDITOR OF THIS JOURNAL would be glad to receive any items of general interest in regard to local events, or matters that it is desirable to call to the attention of the profession. Letters written for publication or containing items of information should be accompanied by the writer's full name and address, although not necessarily to be published. All communications in regard to editorial work should be addressed to the Editor.

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PUBLICATION OFFICE OF THE JOURNAL.

We again remind the members of the Profession who may be in the city during the meeting of the American Medical Association next week, that the business office is at No. 65 Randolph street, corner of State, in which they will find a clerk at all hours ready to wait upon them. Also, that THE JOURNAL printing office is at No. 68 Wabash avenue, only one square from the Central Music Hall, in which the Association will meet, where the extra volumes of the Transactions, published prior to 1883, are to be found and are for sale. Mr. White, in charge of that office, will be prepared to give any information concerning them that may be desired.

MECHANICAL TREATMENT OF HIP-JOINT DISEASE.

Of late years the attention of the profession has been so much directed to the operative treatment of hip joint disease, that the more conservative method of treatment of the affection has not received the attention merited by the attainable results. It is with pleasure, therefore, that we notice an interesting paper read before the New York Academy of Medicine, on May 5, "On the Ultimate Results of the Mechanical Treatment of Hip-joint Disease. An Analysis of Fifty-one Cases, occurring in the Service of the New York Orthopædic Dispensary and Hospital," by Drs. Newton M. Shaffer and Robert W. Lovett, which may be found in the *New York Medical Journal*, of May 21. The cases upon which the report was based were all *dispensary* cases, no hospital, private, or other cases being considered, and no cases in which the hip affection has been treated by other than mechanical means. It will be seen at once that the most difficult of all cases, dispensary, were selected. With the results obtained it is the object of the paper to show that it is not only possible but comparatively easy to treat hip-joint disease successfully, and satisfactorily with proper facilities; by which is meant a well-equipped shop and a corps of mechanics to make, repair or alter the necessary appliances, and the coöperation of out-door visiting surgeons. A further object of the writers is to show that it is exceptional that homeless or illy cared for children require *prolonged* hospital care in hip-joint disease; and to show that a well-equipped orthopædic dispensary, if properly conducted, can do the work of several large hospitals at far less cost.

In order to arrive at positive and ultimate results when the investigation was begun, no case was to be considered which had not been under the care of the institution from the time of entry to that of final discharge; none which had been entered as "discharged cured" after a final examination; no case which had not been "discharged cured" at least four years prior to the investigation; none except those which presented unmistakable signs of the disease at the first examination; none which had not been at least two years under treatment; none which were not seen or examined after investigation was begun; and all cases within these exclusive conditions were to be classified and reported. These conditions, of course, excluded many interesting and valuable cases, but had the latter been included the facts brought out might have had less value. The general plan of treatment was as follows: In each case reported a long Taylor traction-splint was applied soon after the first examination, and the parents or some friends of the patient were instructed in the use of the apparatus. Unless recumbency was necessary to overcome a malposition of limb, or unless the symptoms were so acute as to demand rest (in which case the patient was visited at home by the visiting surgeon) the patient was allowed almost unlimited exercise in the open air. He was seen at the dispensary every week or two for observation and readjustment of the apparatus, etc. If the condition required recumbency for a month or more, and his home was inadequate, he was placed in one of the wards of the institution, to be removed and returned to the dispensary service as soon as possible.

The aims of the treatment were to: 1. Overcome

by mechanical means any acquired deformity existing before treatment was begun. 2. Protect the diseased joint from traumatism. 3. Permit the patient to have almost unrestricted out-door exercise. 4. Maintain that position of the limb which would reduce deformity to the minimum if ankylosis occurred. Except with the occasional opening of an abscess no operative measures were undertaken in any case. "As a matter of experience abscesses connected with a suppurating hip-joint did no better under antiseptic measures than those opened by simple incision, and neither did so well as those which were allowed to open spontaneously. Cold abscesses were allowed to take their own course, unless they were in a location which interfered with the use of joint protection." The patients were carefully watched, and when they failed to report at the dispensary, they were requested to call, or were visited.

What were the results? Of the 51 cases treated 4 had died, 2 of meningitis, and 2 of pneumonia. Six had relapses, after being under treatment 2½, 4, (3), 5, and 7 years. The remaining 41 were seen and carefully examined, except 2, who were reported to be in excellent health. The 39 were carefully examined and measured. These 39 had been discharged as cured between 1875 and 1882. They had been under treatment from 2 to 8 years; they had had hip-disease from less than 6 months to 9 years (2 for an indefinite period) before treatment was begun. Abscess occurred in some stage of the disease in 27 cases. From this paper which is worthy of the most careful study, it appears that the amount of shortening of the leg is not dependent on the presence or absence of abscess, that it is less in children who are cured before 10 years, and that it apparently increases after that age is passed. It also appears that shortening increases slightly after the joint disease is arrested, which seems to prove that the affected limb did not grow so fast as its mate.

Muscular atrophy is always present in hip-joint disease. It persists after the disease is arrested and the apparatus is removed, and it may often improve after treatment is stopped, but never wholly disappears.

The amount of motion in the joint when the disease is arrested and the apparatus is removed is very apt to diminish somewhat in the course of years; but recovery with perfect motion is not impossible, or indeed unlikely. The presence or absence of abscess has no apparent effect on the amount of motion obtained.

Ankylosis being the result most likely to occur, it is important to study the ultimate position of the limb, so that, if ankylosis occurs, the most useful position will result.

Adduction, rather than flexion, is the ultimate position to be avoided, and adduction is apt to occur after the joint seems to be free from inflammation and the apparatus is removed.

Non-deforming club-foot, or even a considerable degree of acquired talipes equinus, may occur when there is much shortening of the leg with flexion of the thigh.

True lateral curvature with rotation occurs very exceptionally, if at all, as the result of even great inequality in the length of the lower extremities, only one case being found in the series, and that not a true rotation curve.

A comparison of the results reported with the published results of excision of the head of the femur leads the authors of the paper to the conclusion that the conservative methods of treatment here described promise much better ultimate results than excision of the joint, aside from the greater mortality attending the operation.

The authors summarize the results of their investigations as follows: Of 51 patients discharged as cured over four years ago, 4 have died, 6 have had relapse, and 41 have apparently been cured of the disease. Of the 4 who died, 2 only had presumably tubercular disease, the other 2 dying of an acute lesion. Of the 6 who had relapse, 2 are now under active treatment with a prospect of a speedy cure, and 2 have been cured a second time. One has been in bed a year after excision of the joint, the other is on crutches. Of the 41 who recovered there is not a single individual who is incapacitated from doing a full day's work at his or her trade or occupation. Only one, a boy who had suffered from both Pott's disease and hip-joint disease, used a cane, and none used crutches. There are, among those who recovered, printers, glaziers, machinists, errand-boys, shop-girls, dress-makers, and many children attending the public schools—all at their work and none with evidences of active tubercular disease or any serious incapacity arising from the condition for which they were treated years before.

CLASS MORTALITY IN THE UNITED KINGDOM.

The causes which govern the mortality among different classes and ranks in the United Kingdom form the subject of an interesting paper which has just been read before the Statistical Society by MR.

NOEL HUMPHREYS, a well-known authority upon topics of this character. The marked decline in the English death-rate during the last eleven years is accepted as proof that the public health is better cared for now than formerly, and that the large expenditure upon sanitary works is bringing substantial return for money in the shape of improved health and a prolongation of human life. The death-rate in the City of London a few weeks ago was almost down to vanishing point, the mortality per thousand of the population being the lowest the city has yet known. Taking the whole country, however, not only are there local variations in the death-rate, but the mortality varies according to the grade of society to which the statistics refer.

What may be termed a simple inquiry on the subject has been made in the case of Dublin, and the facts which have been brought to light reveal such startling contrasts between the death-rates of the several social classes as to make it obviously desirable to discover whether the phenomenon repeats itself in the case of English towns. Already some facts bearing on the question are forthcoming, and these tend to show, in regard to England, "sufficiently wide contrasts between the rates of mortality among the professional and independent and the working classes to supply material for the gravest consideration of politicians, as well as sanitary reformers." Concerning the distribution of diseases, the Dublin inquiry is replete with results which appear almost anomalous on the surface, sometimes showing that the poor enjoy a greater immunity than the rich. Thus it was found that diphtheria was only slightly prevalent among the laboring classes; the artisans had more of it, and the professional class still more, while the middle class suffered most, and also had the highest death-rate from enteric fever. This particular experience is not confined to Dublin, but has also been noticed at Glasgow, and the only available explanation is one which says little for the value of some of our modern sanitary works. On the whole, the Dublin statistics indicate that the poor are the principal sufferers from zymotic disease, notwithstanding the remarkable exceptions just mentioned. The zymotic death-rate was found to be three times as great among the general service class—that is to say, the mass of the working population—as among those engaged in professional pursuits. The mortality from measles was nearly ten times as great in the general service class as in the professional and independent class, and from whooping-cough more than four times as great. It is worthy of note that the death-rate from phthisis during the period of observation was 70 per cent. more in Dublin than in London, and was more than four times as fatal among the general service class as among persons of professional standing. Mortality from lung disease followed a similar law, though in a somewhat less degree.

The investigations of Dr. Ogle show that the mortality of males between the ages of 25 and 65, occupied as agricultural laborers, gardeners and nurserymen, is not much greater than that of clergymen. It is even considerably less than that of barristers and solicitors, or of medical practitioners. Thus poverty and hardship appear to play a very subordinate part in shortening human life, and classes far removed from each other in the matter of social status enjoy equal vitality. On the whole, there is a marked difference between the death-rate of the upper and lower classes, yet there are instructive exceptions to the rule. That which kills is not mere poverty or hard work; there must be the accompaniment of dirty homes, impure air, and more especially intemperance, to render life precarious. Neither will the possession of ample means and apparently healthy surroundings give all the security that might be expected, if judged by the fact that barristers and solicitors die earlier than the poor cottagers of the rural districts. Still, these professional classes make their appearance among those who have the lower death-rates. The truth remains that, on the whole, the poor die first. The untoward influence of poverty appears in the large towns. Laborers may be healthy in the country, but in London they have a high mortality. Work in the open air is not sufficient to counteract adverse influences of another sort, as shown by the high death-rate of those engaged in the cab and omnibus service. These die twice as fast as the gardener and agricultural laborer. Still more severe is the mortality among costermongers, hawkers and street sellers. Curiously enough, the mortality among hotel servants is nearly four times as great as that of the clerical class. Hotel service seems to be more fatal to human life than the occupation of the Cornish miner. One of the apparent anomalies connected with the rates of mortality is the high and increasing death-rate among medical men. This has been recently made the subject of a special and interesting paper by Dr. Ogle. It certainly calls for remark, and indeed for regret, that while the mortality of the population is on the decline, those who are more directly concerned in curing disease and preserving life, are themselves the peculiar victims of that fate which they are instrumental in averting from others.

In estimating the relative mortality of different classes in the community, regard has to be paid to

the proportion of children. This varies greatly in the different parts of the social scale. Thus Dr. Grimshaw found that a thousand of the professional and independent classes included only seventy-five children under five years of age, while a thousand of the artisan class contained one hundred and twenty-one such children. The Dublin statistics further prove that the annual mortality among children under five years of age is five times as great among the working population as in the professional and independent classes. Further on in life the balance keeps in the same direction, though in a less degree. Special attention is drawn to the enormous waste of infant life among the working population. It is a striking fact that this "wholesale slaughter of the sickly and weakly children under five years of age" does not verify the favorite theory of many vital statisticians, that those who survive are capable of living long. That the children of the poor need not die so young is proved by the statistics of the Peabody Buildings, situated in various parts of London, and housing some twenty thousand persons belonging to the artisan and laboring classs. The low rate of child mortality in that instance shows that one cause of early death is to be found in the character of the dwellings, though to this must be added the habits of the people themselves. The Peabody population is assuredly living in a higher scale of civilization than the mass of the London poor, so far as personal conduct is concerned. There is abundant scope for the saving of child life among the poor, it is however a painful thought that the lives thus spared may help to swell that enormous mass of indigence which hangs already as a burden on the state. The solving of the sanitary problem will leave other problems to be faced, and will rather add to the complexity of some of these.

THOMAS F. ROCHESTER, M.D., one of the most eminent members of the profession in the western part of New York, died at his home in Buffalo, May 24, 1887. He was born in Rochester, N. Y., in 1823. He graduated in medicine in 1848, and in 1853 accepted a professorship in the Medical Department of the University of Buffalo, and removed to that city, where he soon won a high reputation as a practitioner and teacher of medicine, and sustained it until his death.

DR. MORELL MACKENZIE AND THE CROWN PRINCE OF GERMANY.—For several days reports have reached this country of the serious illness of Prince Frederick William, who is suffering with a serious affection of the throat. A dispatch of May 30 says that Virchow determined by a microscopical examination that the growth is not carcinomatous. Dr. Morrell Mackenzie was called to Berlin to see the Prince, and it is said that his early arrival averted a thyrotomy. He removed about two-thirds of the growth. Dr. Mackenzie will go to Germany again in a few days. His call to Germany to see the Crown Prince is a merited honor, and shows that scientific worth is not estimated by geographical boundaries.

NEW YORK STATE MEDICAL ASSOCIATION—*Third District Branch.*—This Branch of the State Association will hold its next meeting in Odd-Fellows Hall, Elmira, N. Y., Thursday, June 16, 1887, commencing at 10 A.M. The programme embraces a large number of interesting papers, with a banquet in the evening.

DR. EDMOND FELIX ALFRED VULPIAN, widely known as the Dean of the Faculty of the French Academy of Medicine, died in Paris, May 18, 1887, aged 60 years.

SOCIETY PROCEEDINGS.

MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA.

Regular Meeting, March 23, 1887.

THE VICE-PRESIDENT, D. S. LAMB, M.D., IN THE CHAIR.

DR. J. B. HAMILTON gave the history and presented a specimen of

CANCER OF THE STOMACH AND PANCREAS.

The patient was a lady, 69 years of age, who first came under observation about three months ago, suffering from an injury to the hip joint. He found evidences of an old contusion, but there was general debility and anorexia. On palpation, there was found a perceptible tumor in the left hypochondriac region, which seemed to be enlargement of the spleen. There was some pain, a little jaundice, but no vomiting. The patient was not seen again for about a month, when the jaundice had deepened, the pain had become more constant, there was complete anorexia, the patient had become greatly emaciated, and the tumor was projecting in the left hypochondrium. The symptoms intensified until last evening, when the patient died. There was considerable vomiting in the last two or three days of her life, and for the last twenty-four hours, there was characteristic black vomit, previous to which time it had not been positively demonstrated that the stomach was involved. The specimen showed carcinoma of the pancreas, and a large cancerous mass occupying the posterior wall of the stomach involv-

ing the inner coats. The mesenteric glands in the vicinity were infiltrated, and the stomach was adherent to the abdominal parieties. He had been surprised to see so much disease of the stomach, with such negative symptoms, and accounted for the absence of vomiting by the fact that the pylorus was not involved, and the passage consequently unobstructed. The spleen was greatly atrophied.

In reply to a question by Dr. McArdle, he said there had been some diarrhœa at intervals, and within the last three or four days, but it had not been a prominent symptom.

Dr. S. C. Busey said that the absence of vomiting was probably accounted for as Dr. Hamilton says. The absence of pain, however, which is not uncommon in cancer of the stomach alone, is very unusual when both stomach and pancreas are involved.

Dr. Samuel S. Adams read a paper on

CIRCUMCISION FOR THE CURE OF ENURESIS.

He said that several years ago he had advocated circumcision for the cure of incontinence of urine only under certain conditions in a small class of patients. Further experience had convinced him that the views then held should be modified in order to broaden the scope of the operation. After the eighteenth month a healthy child should pass urine voluntarily; passing it involuntarily he deemed due to pathological cause and not to carelessness. Instead of accepting the popular belief that incontinence is due to laziness, he had been able to detect a specific pathological state in all his cases. Boys have been repeatedly and unmercifully punished for bedwetting when they were powerless to control the sphincter on account of disease. Again, others let the disease run on, hoping that education and refinement will effect a cure, or expect it to be relieved by the establishment of puberty. In too many cases the disease is not treated, and finally psychical changes take place. The boy's whole disposition is altered, and he presents a striking likeness of the onanist.

The disease is divided into three classes: In the first there is a constant dribbling of urine day and night. This is infrequent, and is associated with some serious pathological state; consequently it does not fall within the scope of this paper. In the second class, the incontinence is intermittent in character and occurs in the day as well as at night.

The urine is retained for a short time when the desire to void it comes, but before the child reaches a convenient place the sphincter relaxes and the child soils his clothes. But our interest is in the third class, because of its frequency, its nocturnal character, its possible concealment for years, and the promptness with which it yields to treatment.

It is the children of this class who are so frequently punished for bedwetting when they are as powerless to control the sphincter during the night as those of the two preceeding classes during the day. Dr. Adams thought he could safely add another class, although it might be claimed that it properly belonged to vesical hyperæsthesia. In these the urine is only held for a short time when there is an incontrollable desire to void it. Clinical observation warranted him in making such a classification. This position is strengthened by the fact, that the treatment applicable to this form is similar to that in the others and is equally as successful.

Formerly he did not advocate circumcision in all cases of elongated prepuce, because he believed that if the adhesions were broken up, thus rendering the prepuce capable of retraction, the incontinence would be cured. He had learned by more extended clinical experience that there are a great number of cases that will not be cured as long as the redundant prepuce remains. In a large majority of cases destruction of the adhesions will only afford temporary relief. Where phymosis exist there seems to be no question about the surgical procedure. It is in those with the retractible prepuce that the propriety of circumcision is called in question. In children under 8 years physicians operate without hesitancy; after this-age there is a tendency to delay operative measures until the child's health is impaired.

Dr. Adams then gave the clinical histories of the classes and described the methods of treatment that had been applied, and finally abandoned. The disease becomes so bad and the person so filthy, that the child is brought to the surgeon. He finds the prepuce projecting from one-fourth to one-half inch beyond the meatus; the opening is small and its margin is irritated; and on retracting it he finds an ichorous, foul-smelling collection behind the corona, and the glands irritated and injected.

The nerve-supply of the penis is derived from the pudic nerve, giving branches to the musculi-bulbo and ischio cavernosa, and then passing to the glans where it breaks up in sensory filaments. A portion of these final branches possess a special kind of end-bulb, discovered by Kraus, and called genital corpuscles. It also receives branches from the hypogastric plexus. The upper part of the bladder receives its supply from the hypogastric plexus and the base and neck from the fourth sacral nerve.

It seems reasonable that an irritation of the terminal filaments of the pudic and hypogastric distributed on and around the glans penis, being of sufficient intensity to overcome their spinal ganglionic termination, will also expend its force on the centre of urination and the bladder will be emptied. If the prepuce covers the glans in the adult, the greatest care has to be taken to secure cleanliness and prevent inflammation. The natural secretions soon become offensive and irritating, causing a vesicular inflammation of the corona and adjacent mucous membrane, which is characterized by intense itching, burning, foul odor, painful erections and frequent micturition. This condition is seldom seen in those who have the glans uncovered. Such conditions must occur frequently in the child, that even by the strictest supervision will not regard the hygiene of its person. In only one instance had he known enuresis to continue after circumcision. This child he had previously treated for gonorrhœa so that the continuance of the incontinence might be due to stricture; however, this was only presumptive as the boy would not permit another examination.

DR. T. C. SMITH said that according to his experience the majority of cases of incontinence of urine had been in females, and he would like to ask Dr. Adams what he would do in such cases?

DR. G. L. MAGRUDER stated that he had been interested in the subject for several years, and was glad to hear Dr. Adams express himself so positively in favor of this operation. He is in accord with what he has said, and even goes further and believes in the operation as a means of relieving constant dribbling.

His service at the Central Dispensary has confirmed the opinion he expressed so early as 1879, when he first advocated circumcision for the relief of this class of troubles. In his experience enuresis is cured at once by circumcision if the parts heal by first intention; if not and there is some inflammation, the trouble may continue until it subsides. His experience as to the relative frequency in the sexes does not coincide with Dr. Smith's. At the Central Dispensary the proportion is about ten boys to one girl with incontinence. He often finds, however, a vulvitis, a vaginitis, or a constriction about the clitoris, which last he breaks down by passing a probe around the organ. He also finds that females respond to medicinal treatment more readily than do the males.

In this connection he has found strychnia the most valuable drug, with belladonna next, and where there is a bad state of health, syrup of the iodide of iron. He is not an enthusiast about this last, in all cases, but in females he considers it especially valuable.

DR. T. C. SMITH said that he has never had a large experience with circumcision for enuresis, but he considers it a valuable operation, and one that is not often enough done. If some dynamic force could be found which would compel the whole male population to allow their penis to be examined by some doctor, what a variety of pathological conditions we should find. The other day a man came to his office with a picture of his own penis and asked him what could be done with such an organ. Dr. Smith persuaded the patient to let him see the original of the picture, when he found a pin-hole prepuce with a portion of the glans penis sticking through it like a polypus. Years ago he had treated this man for asthma, and after months of treatment he was no better. The patient went from one to another doctor without being benefited of his asthma. Dr. Smith said that he was positive that if he had known of the condition of the prepuce when he first attended the case for asthma, he could have cured his patient by circumcision. This man was married and his wife had given birth to a puny child which had died in about six weeks. The asthma still continues, but he does not expect to cure it by circumcision which he has recommended.

DR. J. FORD THOMPSON rarely stops to study up the reflexes when called to see a child with a long prepuce. It is his invariable custom to recommend circumcision when he finds a long or adherent prepuce. It is, however, remarkable how some men escape all trouble with this affection. The other day he operated upon a man of 80 who had never seen his glans penis. The man had been married forty years and had a large family of children. He never had had the slightest trouble with his penis and only came to consult a doctor because of a slight inflammation around the meatus, which bothered him on micturition. He has also had two similar cases in men over 70. In one of these cases cocaine was used; the patient suffered no pain whatever and continued telling a story which he had begun before the operation. He has been called upon to operate for incontinence less frequently than for other conditions, but he can recollect but one case of incontinence that was not relieved by the operation Many circumcisions, are however, done so early that one cannot say what might have happened without the operation. It is the rule to look at the penis in every case of chronic disease, and he is often astonished to see the number of children that require the operation. He has circumcised in apparent cases of bone and hip disease with relief to the child, and he has recently found several cases of club-foot and hare-lip which have needed the operation. Some time ago he operated for Dr. Busey, on a child with epilepsy, who had been treated unsuccessfully by some of the best doctors in another city. The result was a perfect cure. Dilating the prepuce or simply breaking down the adhesions is of little or no value. The only satisfactory way to do is to slit the prepuce back to the sulcus, and to cut off enough to keep the glans uncovered. He has operated on adults who have been virtually impotent on account of a long tight foreskin. A man of 35 once told him that though he had been with women a great deal, he had never completed the act of copulation, because when he got an erection of the penis the irritation of the tight prepuce forced the organism before he reached the woman. Dr. Thompson found an adherent prepuce and a swollen glans, and expressed the conviction that circumcision would make him a new man. The operation was done, and in six months the patient came back again, saying that he could now enjoy himself as other men, and bringing tangible evidence that he had at all events made the effort.

He saw a child with the late Dr. Newman that had been treated for hip-disease. A careful examination of the hip showed that there was no disease in that region, but upon examining the penis a long and adherent prepuce was found. Dr. T. concluded that therein lay the trouble, but this opinion was not coincided in by Dr. Newman. Circumcision was, however, performed and in six months the child was well. Of course, a tight prepuce is not the cause of hip-disease, but the symptoms produced by it sometimes simulate hip or spinal trouble. His opinion is, that it is the duty of every doctor to examine the penis of every new-born male child, and where there is a long adherent prepuce to operate even before the nervous symptoms begin. Even retained smegma may cause all the symptoms of a tight foreskin, but this cannot occur if the prepuce is removed.

DR. T. E. MACARDLE agrees with Dr. Adams when he reccommends circumcision without wasting

time in attempting a cure with drugs. He also agrees with Dr. Magruder that medicinal treatment is more efficacious on females with incontinence than on males. Belladonna he has found the most useful drug in these cases. In the female ascarides or filth may be the cause of the enuresis, and the removal of the cause will often effect a cure without medication.

Dr. S. C. Busey remarked that what has been said with regard to the effects of a long prepuce, is true in many cases; he coincides to a great extent with the opinions expressed. There are, however, many cases cured without resorting to circumcision. Vesical irritation, for instance, is a not infrequent cause of incontinence, but may be cured by drugs. One remedy will not cure all cases, but the one which he has found most useful has been belladonna. In his practice the proportion has not been so high as ten boys to one girl, troubled with incontinence. While circumcision is an operation always necessary when it causes retention of urine, it does not always cure incontinence. He would like to know whether Jewish children are much troubled with incontinence of urine. If circumcision has such a good effect, the custom among the Jews of circumcision on the eighth day must make enuresis a rare disease with that race. The boy referred to had been a masturbator and an epileptic, but since the operation, ten months ago, he has had no return of the convulsions. He has also seen children with epileptiform convulsions occurring every three or four weeks, cured by circumcision, while Dr. Sayre has well demonstrated that some very peculiar nervous symptoms have been improved or cured by the operation. Idiocy has not, however, been completely cured by circumcision. There must be other causes besides a tight prepuce for the trouble occurs so frequently in females, even where there is no local irritation. As has been said, medicine acts better upon this sex than males. The medication need not be addressed directly to the local trouble, but to any constitutional cachexia that may be present, and for this purpose nothing is better than the syrup of the iodide of iron. The cause must always be sought out and whether local or not, hygiene, food and dress must be considered in the treatment.

In conclusion, he would say, that whilst he considered circumcision a valuable operation from a hygienic point of view, and would advise it in all cases of long prepuce, yet he believes that many cases of incontinence can be cured without resorting to it at all.

Dr. G. L. Magruder agrees with Dr. Thompson as to the advisability of examining the genitals of male children. In reply to Dr. T.'s remark that he had never seen a statement that a tight prepuce was the cause of hip-disease, would call attention to the observation of Dr. Barwell, who investigated this subject, and in 100 cases of hip-trouble examined, only six had a normal foreskin. Barwell has divided this condition of the penis into five degrees. The first degree, in which there is only a pin-hole opening in the prepuce, and so on down to the fifth degree, in which the organ is normal.

He also requested a friend to find the number of hip-joint cases in a hospital frequented by Jews, and the friend replied, "that there were no Jewish patients with hip-disease." It seems, therefore, that there is some connection between a tight prepuce and hip-joint trouble. There is a nerve which leads from the sacral plexus into the hip joint. Barwell thinks that the influence of irritation at the glans penis can readily modify the trophic changes that take place in the hip at this time of life. On the other hand, Sayre asserts that the hip trouble is from falling down, an accident that children with tight foreskins are especially liable to owing to the weakening of the muscles produced by the condition of the genitals. Since his connection with the Central Dispensary he has seen many cases of club-foot, but only two of them have been in girls. A few weeks ago he saw a child of three months who had never had a comfortable night's rest since its birth, and who had grown peevish and emaciated. The trouble was constant priapism. Two homœopaths had been pouring cocaine into the urethra in hopes that that would bring relief, but without effect. Upon examination, he found the prepuce attached over the whole of the glans, and a quantity of smegma collected behind it. He broke down the adhesions, and finding further a short frenum it was cut. The child was almost instantly relieved and has been progressing favorably ever since.

Dr. Samuel S. Adams, in closing said, that he had limited his paper to circumcision where there was an elongated prepuce, and he consequently had not encroached upon Dr. Magruder's paper, which took in a broader field. He is glad to see that Dr. Thompson has come to believe in circumcision for general symptoms. Dr. Adams, continuing, said that he had always advocated circumcision in elongated prepuce, and that this paper was a reiteration of his belief expressed when Dr. Magruder read the paper which had been alluded to.

AMERICAN SURGICAL ASSOCIATION.

Eighth Annual Session held in the Army Medical Museum, Washington, D. C., May 11, 12, 13 and 14, 1887.

Tuesday, May 12—Second Day.

Afternoon Session.

(*Concluded from page 609.*)

Dr. R. A. Kinloch, of Charleston, S. C., read a paper on

PISTOL-SHOT WOUND OF THE ABDOMEN TREATED BY LAPAROTOMY AND SUTURING THE INTESTINES.

J. B., colored, aged 27, was admitted into the City Hospital, January 21. He had been shot two hours before in the abdomen with a pistol ball. The ball entered 1½ inches to the left of the umbilicus. There was slight shock. At 10 P.M. ½ grain of morphia was given hypodermically, and shortly afterwards anæsthesia was induced. Penetration of the peritoneum was first determined, and the abdomen was

then opened by median incision. The intestines were examined piece by piece and wrapped in towels wrung out of a 1–10,000 bichloride of mercury solution. The jejunum presented four wounds. The ileum had two wounds. The mesentery was perforated in two places, and was also badly torn. There was free bleeding from a mesenteric branch, which was controlled by silk ligature. All the wounds were closed with the Lembert suture, using a fine round needle and antiseptic silk. The wounds of the mesentery were brought together as far as was possible, but there was an infiltration of blood which could not be removed. The abdominal cavity was washed out with a weak solution of hydrarg. bichloride, the abdominal wound was closed with silver sutures, and a large rubber drainage tube introduced. Antiseptic precautions were observed throughout the operation. The next morning vomiting occurred, and an examination of the wound showed that a suture had given way and a knuckle of intestine protruded. This was returned and the opening closed. At 5 P.M. the temperature was 102°. Vomiting again occurred, and shortly after midnight the patient expired suddenly.

Autopsy.—No adhesion of the parietal peritoneum had occurred. Half a pint of dark sero-sanguinolent fluid was found in the cavity. All the intestinal sutures had held and there was no fæcal extravasation. A circumscribed abscess was discovered in the meso-colon out of the line of the bullet. The ball was found behind the body of the fourth lumbar vertebræ on the left side.

This was the third case in which the author had performed laparotomy for bullet wounds of the abdomen without visceral protrusion. In two cases of such injury the patients recovered without operation. The first operation was performed May 27, 1883. This patient recovered. This was the first time that laparotomy was done for gunshot wound without protrusion.

DR. W. W. KEEN, of Philadelphia, reported a case of

PISTOL-SHOT WOUND OF THE ABDOMEN, INVOLVING THE LIVER, STOMACH, SUPERIOR MESENTERIC VEIN, INTESTINE AND KIDNEY; LAPAROTOMY; NEPHRECTOMY; DEATH ON THE FIFTEENTH DAY.

A girl of nearly 18 shot herself with a pistol, calibre No. 32, at 6:30 A.M., April 1, 1887. The ball had entered over the liver, and was found lying under the skin of the left flank. I saw her at 2 P.M. The wound of entrance was over the ninth rib, which was fractured, 4½ inches above the level of the navel, and 3¾ inches to the right of the median line. Skin not burned. The ball was located 8 inches to the left of the median line and 1½ inches above the level of the navel. There was moderate tenderness over the entire belly, hepatic dulness not changed, stomach resonant from fifth interspace, no cough, no râles, vocal fremitus normal. Renal dulness began at tenth rib on left side and was the same on the two sides. There was severe pain in the left shoulder. She had vomited 1½ drachm of clear bright blood, she told me, immediately after the accident. About a pint of urine, the first since the accident, was drawn by the catheter. It was not bloody. Pulse 104; repiration 30; no material rise of temperature. As after consultation it was deemed almost certain that the belly was invaded by the ball, exploratory laparotomy was advised, consented to, and begun at 3 P.M., and lasted nearly three hours, with every antiseptic precaution. The ball was easily removed just under the skin. Neither wound could be traced positively into the belly. On opening the belly neither blood nor serum escaped, nor was any extravasated food or fæces noticed. There was no peritonitis. Two fingers were passed in, and an effort made to discover the wound of entrance or exit, without any being revealed by touch. The wound was then enlarged and the stomach drawn out. A small round wound near the pylorus was found and was closed by four sutures (Lembert) of the finest iron-dyed silk, a round ordinary sewing needle being used. This wound was practically closed by the pouting mucous membrane. As the ball had entered the stomach, search was made for the necessary wound of exit. None was to be found, but the manipulation showed that a small amount of bloody serum existed in the belly, and a large area of extravasation was seen in the mesentery. But little blood had escaped into the peritoneal cavity. The mesentery was carefully torn through and a small artery tied. The chief bleeding came from a hole nearly ⅛ inch in diameter in a large vein, so large and lax that at first I thought it the vena cava, but its position just below the head of the pancreas convinced me that it was a large superior mesenteric vein just before it forms the portal vein. After much difficulty I seized it with hæmostatic forceps, and placed a lateral ligature of chromicized catgut on it.

The anterior border of the liver had been scalloped by the ball, but as there was no bleeding, it was let alone. In addition, a large wound in a coil of small intestine in the left flank had been found. Ten Lembert sutures were used in closing it. Returning now to the stomach, a very careful search was again made for the wound of exit. It was found obscured by a slight coating of blood. This was closed by three black silk Lembert sutures. A systematic investigation of the entire bowel from the stomach to the sigmoid flexure showed no other wounds. The left kidney was badly lacerated, and was immediately removed by peeling it out of its capsule and tying the pedicle with a stout silk ligature. A rubber drainage-tube was inserted through the wound of exit into the abdominal cavity. The wound of entrance was cleansed and closed by three stitches, and the wound of exit by two. Sublimate gauze, rubber dam, and a wide flannel bandage completed the dressing.

On the 8th she had a chill lasting twelve minutes, and the temperature rose to 104°, but as the most careful examination revealed no spot of special tenderness, no dulness, no fluctuation, and she was almost, it seemed, *in articulo mortis*, it was not deemed prudent to reopen the belly.

On the 10th she improved somewhat. On the 13th she had another chill with a temperature of 105.4°,

had vomited several times, and also had some involuntary evacuations. But as her condition was fair, pulse 136, temp. 101.4°, the belly was reopened and explored. The intestines were bright and glistening and no peritonitis existed. Surgical bimanual examination revealed no pus or special tenderness at the site of the removed kidney, or, so far as it could be located, at the intestinal wound. No shock followed. The next day (fourteenth) she had two bloody motions and gradually failed, dying on the fifteenth day.

The autopsy revealed general peritonitis, but no free pus was found anywhere. Only one wound was found in the stomach, near the pylorus, and this was healed, the four stitches being seen in place. The blood in the mesentery was disintegrating and suppurating, though no abscess existed, nor was there any free pus in the peritoneal cavity. The suppuration was chiefly marked along the mesenteric attachment of the intestine. On the other side of the mesentery, corresponding in position to this wound, was a spot in the bowel wall as large as a five-cent coin, which was gangrenous, and in its centre were two perforations of the bowel. No wound was found except that discovered at the operation. No trouble was found at the site of the removed kidney. Although it was nearly ten hours from the accident to the time when the intestines and stomach were sutured, no intestinal or gastric juice or fluid escaped, though the intestinal wound was so large and vomiting occurred three times.

The kidney, I believe, has never before been removed at a laparotomy for gunshot wound, but it was clearly the right thing to do. The day following the operation the remaining kidney worked badly, only 3½ ounces of albuminous urine being secreted. But the next two days dispelled all anxiety on this score, the urine rising to 24 and 40 ounces respectively, and the albumen soon disappeared. The early and marked compensatory enlargement of the right kidney is also of great interest and importance, though, of course, now well known to follow nephrectomy.

Dr. P. S. Conner, of Cincinnati, remarked that the most important point to determine is, when should the abdominal cavity be opened? If there is extravasation of bile, fæces or urine through the wound, the nature of the injury is clear, but in the absence of these signs there is much doubt. There is no single symptom or collection of symptoms to be relied upon. He had been disposed to attach some value to the presence of profound depression of temperature. If the temperature remains subnormal four, five or six hours, penetration and perforation may be considered almost certain. Diagnostial laparotomy is admirable in certain cases. In private practice we have to be largely governed by the opinions of the patient and his friends. Most of these cases necessarily involve legal investigation, and it is a very simple matter to show that death resulted not from the original injury but from the surgeon's knife. While he considered it wise to lay down the general rule that penetrating wounds of the abdomen, and still more perforating wounds of the viscera, should be submitted to laparotomy, at the same time he held that we are not justified in laying this down as a hard and fast rule.

Dr. Moses Gunn, of Chicago: When Dr. Sims proposed this operation a few years ago the profession were not ready to accept it. All are now prepared to say that it is a proper measure to pursue, but the only question is how to make the diagnosis? We have, as has been said, no positive signs of visceral injury. He thought that we are fully warranted in saying that we may resort to laparotomy for purposes of diagnosis when we are in doubt.

Dr. T. G. Richardson, of New Orleans, stated that the statistics of the Charity Hospital of New Orleans showed that in the last five years there had been thirty-one cases of penetrating knife wounds of the abdomen, of which twenty-four recovered and seven died. There were thirty-three cases of gunshot wounds of the abdomen, with thirteen recoveries and twenty deaths. These cases were treated on the expectant plan.

Dr. D. Hayes Agnew, of Philadelphia, had very strong convictions in regard to laparotomy. He believed that where there is a reasonable degree of evidence that there is a penetrating wound of the abdominal wall, especially if a shot wound, it is the surgeon's duty to make an exploratory incision. We are not to be deterred by the possibility of some legal technicality if the case should come into court. We are to do our duty without reference to the consequences.

Drs. David Prince, Joseph Ransohoff and N. P. Dandridge also reported cases bearing upon this discussion.

Dr. J. Edwin Michael, of Baltimore, read a report of a case of

VENTRAL HERNIA SUCCESSFULLY TREATED BY OPERATION, WITH A SUGGESTION AS TO THE METHOD OF OPERATING.

Mrs. F., stout woman, 45 years of age, had a ventral hernia resulting from a fall several years previously. Great annoyance was experienced in the use of pads and bandages. The patient insisted on operation, and March 15, 1886, the operation was performed. Antiseptic precautions were adopted. Free incision was made in the median line. The sac was carefully separated from surrounding tissues. It was then emptied of its contents and opened. The sac was cut off close to the margin of the ring. Strong silver wire sutures were passed a little less than one-half an inch apart, having a hold of one-half to three-fourths inch. The sutures included the peritoneal, muscular and tendinous structures only. These were twisted and perforated shot employed. The wire was then cut off close. The wound united rapidly. In October, examination of the wound showed it to be firmly united. The sutures could be felt, but gave no inconvenience. In his remarks the speaker stated that his object in using the wire sutures in this manner was the expectation that they would be surrounded by a mass of cicatricial tissue, making a permanent closure of the ring. As far as he was aware, he had used the wire for this purpose without precedent.

A paper on *Prognosis in Sarcomata of the Breast*, by S. W. Gross, of Philadelphia, was read by title.

DR. D. HAYES AGNEW, of Philadelphia, read a paper on

THE MEDICO-LEGAL ASPECT OF CRANIAL AND THORACIC WOUNDS (SUICIDAL).

The study of this subject had been suggested to him by a recent case occurring in Newport, Rhode Island. The question was as to the possibility of a cranial wound and a wound of the heart being self-inflicted. A colored man was found one morning lying dead under the breakfast-table. He had food in his mouth, and had a wound of the head and of the heart. The coroner's jury returned a verdict of suicide and the body was buried. Subsequently it was disinterred and the verdict reconsidered, and the conclusion reached that the man had been murdered. Suspicion then fell upon the son-in-law of the man, who had up to this time borne a good reputation. At the trial five medical experts were called for the prosecution, and their general testimony was that these wounds were incompatible with the idea of suicide. Subsequently the prisoner confessed that he had committed the murder. As this was an important question, the author had investigated it. Injury to the brain is not necessarily followed by loss of consciousness or by paralysis. Many cases were cited to show the truth of this statement. Numerous instances of heart injury were given in which, after the reception of the accident, the individual was able to perform many acts. Cases were also given in which persons, in attempting suicide, had produced injuries of the head and of the heart. As the result of his study the speaker concluded that it is possible for a ball to enter the brain without destroying consciousness, although for a moment it may cause mental confusion, and that a suicide may shoot himself in the head and after a moment shoot himself in the heart.

In the discussion which followed numerous cases were related in which the heart or brain had been injured and the individual had lived for some time, and had not been unconscious. Cases were also given in which both a wound of the heart and of the brain had undoubtedly been produced by the individual himself.

FRIDAY, MAY 13.—THIRD DAY.

MORNING SESSION.

The following were elected

OFFICERS FOR THE ENSUING YEAR.

President—Dr. D. Hayes Agnew, of Philadelphia.

Vice-Presidents—Dr. N. Senn, of Milwaukee, and Dr. F. S. Dennis, of New York.

Secretary—Dr. Jacob R. Weist, of Richmond, Ind.

Treasurer—Dr. Phineas S. Conner, of Cincinnati.

Recorder—Dr. J. Ewing Mears, of Philadelphia.

Council—Drs. J. S. Billings, L. McLane Tiffany, Moses Gunn, and R. A. Kinloch.

Chairman of Committee of Arrangements—Dr. John S. Billings, of Washington.

The following were elected

NEW MEMBERS.

Charles B. Porter, M.D., of Boston; William M. Mastin, M.D., Mobile, Ala.; and Morris H. Richardson, M.D., Boston, Mass.

The next meeting to be held at the call of the President.

DR. L. MCLANE TIFFANY, of Baltimore, read a paper on

SURGICAL DISEASES OF THE WHITE AND COLORED RACES COMPARED.

The paper was based on the record of 4930 cases, studied during a period of thirty-four months in a general hospital. The percentages of the affections were given in detail. The paper was simply intended as a preliminary communication, and as a result of a study of the figures obtained the following suggestions were made:

1. Surgical affections follow different courses in the white and colored races, under identical hygienic surroundings.

2. Surgical injuries and operations are better borne by negroes than by whites.

3. Surgical diseases involving the lymphatic system, especially tubercular, are more fatal and more rapidly fatal in negroes than in whites.

4. Congenital deformities are rarer in negroes than in whites.

5. The surgical differences observed in whites and negroes are due to racial peculiarities.

DR. CHRISTOPHER JOHNSTON, of Baltimore, said that his experience indicates that there are individual as well as racial peculiarities. These are most striking in proportion to the pureness of the blood. He regarded the negro as a good subject for surgical operation. He had never seen carbuncle in negro. He does not recall a cleft palate or hare lip in the darker individuals. Epithelioma is infrequent. Fibromas are quite frequent. He had found that in the negro the skin and white tissues are more frequently the seat of certain diseases than the same tissues in the white.

DR. T. H. RICHARDSON, of New Orleans, presented a detailed report of the statistics of the Charity Hospital, bearing upon this point. He had found congenital deformities rarely in the negro.

DR. E. H. GREGORY, of St. Louis, had seen keloid much more frequently in negro than in white, and had never seen multiple keloid in the white race. The ability of negroes to stand operation may be due to his indifference, and he does not comprehend the magnitude of the operation.

DR. W. T. BRIGGS, of Nashville, said that his experience confirmed the suggestions of Dr. Tiffany. Negroes are very prone to suppuration. It is extremely difficult to prevent suppuration even under strict antiseptic precaution. Negroes bear operations better than whites, but they do not get well so rapidly. While malformations are less frequent, still they do occur. The rarity of hydrocele in the hospital records may be explained by the fact that negroes do not usually seek advice until the tumor has become so large as to give rise to much inconvevience. Ovarian tumor is rare, although he had had one case.

DR. D. W. YANDELL, of Louisville, Ky., had seen

many cases of keloid in the negro, but had not seen a case in the white subject. He had seen but two cases of hydrocele in the negro, and never saw hare lip in the negro. He had seen but two ovarian tumors in the negroes, and never saw epithelioma of the face of a negro. Epilepsy is exceedingly rare in the negro. Tetanus is exceedingly common, especially in the blacker race. Stricture of urethra is exceedingly common among negroes.

Dr. R. A. Kinloch thought that in the pure negro suppuration is less likely to occur than in the white race. As a rule the pure negro is not strumous. Mulattos are, as a rule, strumous. The pure negro bears operation well and recovers promptly.

Dr. A. Vanderveer, during the past twenty years, had seen a great many negroes, United States prisoners, sent to the Albany penitentiary. The vast majority of these die of tuberculosis of some form. Many of them have soft chancre with suppurative buboes. Where there is true Hunterian chancre there has been the characteristic bullet bubo seen in the white race. There are a greater number of perineal abscesses and sinuses than in the white. If operation is done there is less probability of urethral fever.

Dr. B. A. Watson, of Jersey City, read

AN EXPERIMENTAL STUDY OF THE EFFECTS OF PUNCTURE OF THE HEART IN CASES OF CHLOROFORM NARCOSIS.

The results of sixty experiments on dogs were given in detail. The experiment consisted briefly in producing death by chlororom inhalation, and then within from one to three or four minutes an aspirating needle was introduced into the heart through the chest walls, the attempt being to reach the right ventricle. In the first fifty cases the chloroform was administered rapidly and air was excluded as far as was possible. In the last ten the chloroform was administered slowly, and with a large proportion of air. The first forty animals had already suffered some severe traumatic injury, while the last twenty were perfectly healthy animals. The punctures made in these 60 experiments were as follows: Right ventricle 38; left ventricle, 6; right auricle, 6; superior vena cava, 3; inferior vena cava, 2; apex of the heart, 2; and not stated, 1. The resuscitations were as follows: after puncture of the right ventricle, 9; right auricle, 1. The first forty experiments gave only four recoveries, while the last twenty gave six. In only one of the sixty cases did the heart fail to respond to puncture, and in this instance the use of the needle was postponed for four minutes after the cessation of the heart's action, and one minute after breathing had stopped.

Should the puncture be carried into one of the the cavities of the heart in order that blood may be abstracted? In chloroform narcosis the heart is found in diastole and the veins in the lungs are greatly distended with blood. It may therefore theoretically be assumed that blood may be advantageously drawn from the right side of the heart. The author was assured that this procedure was practical and advantageous.

The only deaths during these experiments which could be attributed directly to the puncture, were those in which the needle penetrated the vena cava. In these cases there was profuse hæmorrhage into the thoracic cavity. Punctures made into the auricle are sometimes followed by a flow of blood into the pericardium. Punctures into the ventricle are not attended with any hæmorrhage from the interior of the organ, but there may be a few drops of blood from a wounded cardiac vein.

The following conclusions were reached:

First, Puncture of the heart, especially of the right ventricle, stimulates muscular contractions, and may be advantageously applied in the treatment of chloroform narcosis.

Secondly, The best results are obtained when abstraction of blood from the cavity of the ventricle is combined with the stimulating effects produced by the entrance of the aspiratory needle.

Thirdly, The puncture of the right ventricle is a safer and more efficient operative procedure than the puncture of the right ventricle.

Dr. N. P. Dandridge, of Cincinnati, said: The conditions under which the experiments were made were different from those under which accidents usually occur in human beings. In the latter case, the accident usually occurs after only a small quantity has been taken and often early in its administration. The effect is probably due to a reflex effect upon the inhibitory action of the heart. In the experiments reported puncture was resorted to within one or two minutes after the cessation of the heart's action. In the accidents with chloroform, it is not uncommon to have recovery after apparent cessation of the heart's action for a comparatively longer period. A large number of experiments are required to test the relative value of this procedure as compared with artificial respiration. The use of nitrite of amyl, and particularly with the subcutaneous injection of atropia. This latter can always be done quickly, and has a stimulating effect upon the cardiac and respiratory centres.

Dr. John B. Roberts, of Philadelphia, said that the speaker, while he had shown the comparative inocuousness of the heart with a small needle, had also shown the danger of using chloroform as an anæsthetic in any cases, possibly cases of parturition excepted. His experiments have shown that it is more dangerous to puncture the auricle than the ventricle, which would naturally be suggested by the fact that the auricle has a much thinner wall.

Dr. T. J. Dunott, of Harrisburg, referred to a case in which the heart was twice punctured with an aspiratory needle, and blood drawn from the cavity of the heart. It was a case of dilatation of the heart with general dropsy, etc. The operation was performed by a homeopathic practitioner, under the idea that he was dealing with a case of dropsy of the pericardium. A large quantity of blood was removed, and for a time there was improvement. The symptoms again returned and the operation was repeated with a fatal result.

The committee to which was referred the *Suggestion's contained in the President's Address*, reported

that in view of the satisfactory manner in which the work of the present meeting had been prepared, it saw no reason for a change and did not recommend the appointment of a business committee. It recommended the adoption of the second suggestion with reference to the abrogation of Article 9 of the Constitution. The committee was in accord with the President, but as the article had been introduced at the express desire of the first President of the Association, it was then recommended that it be allowed to remain. The committee recommended the adoption of the suggestion that applications for membership lay over for one year.

AFTERNOON SESSION.

DR. T. J. DUNOTT, of Harrisburg, read a paper on

HYPERTROPHY OF THE TONGUE, OTHERWISE KNOWN AS LINGUA VITULI, LINGUA PROPENDULÆ AND MACROGLOSSIA.

This affection of the tongue, though rare, is mentioned by nearly all surgeons of large experience. The case described by the speaker was that of a girl, 12 years of age, admitted to the Harrisburg Hospital January 6, 1886. The tongue protruded from the mouth a distance of three and five-eighths inches. The lips were greatly distended, and the angles of the mouth not far removed from the external opening of the auditory canal. The greatest width of the tongue was four and three-fourths inches, and the greatest circumference nine and three-fourths inches. The prolapse of the tongue was only of two months' duration, and had begun without apparent cause. The measurements taken one week after admission showed a decided increase in the size of the tongue. The tongue was removed on February 19. After providing against hæmorrhage the organ was removed with scalpel and scissors, the section being so made as to secure a conical stump. All the dense fibro mass was taken away, the weight of the removed portion being over ten ounces. By January 31, the stump was entirely healed. There was no difficulty in keeping the mouth closed. When heard from March 23, she could eat and drink without difficulty and was gaining flesh rapidly. The paper was concluded with an account of the various operations which had been practiced for the removal of the tongue.

DR. L. MCLANE TIFFANY gave the history of a case. A negro girl, 5 years of age, had suffered with hypertrophy of the tongue dating from birth. Ever since the first few months of life, the child had been unable to cover the tongue with its lips. The tongue was removed with the Paquelin cautery. Within a week the patient was eating potatoes and meat, and left the hospital ten days after operation. At this time there was a healthy granulating surface.

DR. J. FORD THOMPSON, of Washington, reported

TWO CASES OF VAGINAL HYSTERECTOMY.

Case 1.—Mrs. A. E., aged 45 years, white, was seen in April, 1885, suffering with malignant disease of the uterus. There was great destruction of the cervix, the ulceration extending above the internal os. On consultation, it was decided to avoid hysterectomy if possible, but to limit the operation to amputation of the cervix with scraping, etc. During the operation the peritoneal cavity was opened. It was then decided to extirpate the uterus. The womb was separated from the bladder in front. A ligature was then placed around each broad ligament and tied. The uterus was then split in two. Each half was then brought down, the broad ligaments tied above the temporary ligatures, and the uterus removed. After thorough cleansing the vagina was tightly packed with iodoform gauze. At the end of the operation the patient was very weak, and notwithstanding all efforts died in the course of twenty-four hours.

Case 2.—Mrs. H. white, aged 55 years, came under observation with cancer of the cervix, in January, 1887. The posterior lip of the cervix was almost entirely destroyed, and the disease had encroached upon the posterior cul-de-sac. The cervical canal was involved at least as high as the internal os. The operation was performed February, 21, 1887, antiseptic precautions being adopted throughout. The dissection was begun at the posterior part, and carried around the cervix. A silk ligature was passed with a long curved needle through the lateral vaginal vault of either side and tied. The inclosed portion was then cut from the uterus. These ligatures presumably enclosed the uterine arteries and the lower part of the broad ligament. The uterus was then separated from the bladder in front, and a loop of silk was attached to the peritoneum. The posterior cul-de-sac was treated in the same way. The uterus was then tilted through the opening, and the broad ligaments transfixed and tied. There was no loss of blood. The peritoneal flaps were then brought together with two catgut sutures and a drainage tube introduced into each angle of the wound. The vagina was packed with iodoform gauze. The patient recovered without any unpleasant symptoms.

DR. T. F. PREWITT, of St. Louis, agreed with the author that extirpation of the uterus is a justifiable operation. He was almost prepared to go further, and say that on the earliest appearance of epithelioma of the cervix the whole organ should be extirpated. He believed that ultimately this will be the course adopted.

DR. E. H. GREGORY said that it was one of the rules of old surgery to save every part possible, and he would no more think of removing the whole lip for limited epithelioma of that part.

DR. R. A. KINLOCH said that in the uterus we have an organ suspended in the pelvis and easily isolated. Now if statistics show that by cutting far and wide without jeopardizing life too much, we can cut short the disease, we are carrying out the rules of old surgery when we do so.

DR. T. G. RICHARDSON reported a case of

ANEURISM OF THE LEFT SUBCLAVIAN ARTERY FOR THE CURE OF WHICH THREE METHODS OF TREATMENT WERE EMPLOYED—DEATH.

The patient, a healthy muscular Irish laborer,

came under observation October 19, 1885. Aneurism of the left subclavian artery was diagnosed. The patient had suffered with syphilis and constitutional measures were first tried. Iodide of potassium in fifteen or twenty grain doses, was given three times a day. At the end of a week no perceptible effect being observed it was discontinued. Direct pressure was next tried, an elastic band with a compress over the vessel was secured to a belt around the waist. This was continued a month, and although it slightly retarded the growth of the swelling, it had had no decided result. The third method, the introduction of surgical pins was next resorted to, nineteen of these measuring an inch and a half in length, were passed through the anterior wall of the tumor at different places. The aneurism was still growing rapidly, and all the pins that could be reached were withdrawn. Some of them had disappeared on account of the swelling which had taken place. An attempt was then made to ligate the axillary artery, but in spite of the utmost care the lower portion of the aneurism was ruptured in the progress of the operation. The wound was at once packed with lint dipped in Monsel's solution. The hæmorrhage having been stopped, half a drachm of a 5 per cent. solution of bichloride of iron was injected into the centre of the tumor. At the end of twenty-four hours no coagulation having taken place, a second injection of twice the strength was employed. The next morning there was a exhausting hæmorrhage, ending fatally in a few hours.

DR. RICHARDSON also reported a case of

FEMORAL ANEURISM CURED BY ELEVATION AND FLEXION OF THE LIMB.

The patient, an Italian, aged 55 years, was admitted to the hospital Dec. 11, 1886, with a large aneurism of the femoral artery four inches below the femoral arch. While the case was being studied the limb was flexed at a right angle at the hip and knee and suspended on a Smith's anterior splint. The next day the pulsation was greatly reduced and the patient was quite comfortable. The treatment was continued and at the end of the third day the tumor was solid. The limb was kept in this position for ten days or two weeks. The patient was discharged cured one week later. The speaker called attention to the fact that there was no direct pressure upon the tumor and that the result was due entirely to flexion and suspension of the limb.

DR. JAMES MCCANN, of Pittsburg, reported a case of

SPLENECTOMY.

The paper was a case in which removal of the spleen had been practiced with recovery of the patient.

A paper entitled *The Study of the Methods of Operation Practiced and the Results Obtained in the treatment of Cleft of the hard and soft Palates, illustrated by the record of Fifty Cases*, by Dr. Ewing Mears, of Philadelphia, was read by title.

A vote of thanks was then extended to the Surgeon-General for the use of the room; to the Cosmos Club for courtesies extended, and to the officers of the Association for the efficient manner in which the proceedings had been conducted.

The association then adjourned to meet at the call of the President.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated Meeting, Thursday, April 7, 1887.

THE PRESIDENT, THOMAS M. DRYSDALE, M.D., IN THE CHAIR.

D. B. C. HIRST read a paper on

THE ETIOLOGY AND TREATMENT OF CASES OF SO-CALLED LATE INFECTION IN THE PUERPERAL STATE.

The title of this paper is, I fear, too pretentious: Its object is merely the brief relation of four cases of so-called late infection in the puerperal state, all, I believe, due to the same cause, all yielding to the same treatment and conveying therefore a lesson of some little interest and value.

The first case was young primapara delivered without difficulty after a moderately long labor. She left her bed on the eleventh day, having had no fever and having manifested no unusual symptom: Two days afterward her cervix was exposed to view by means of a bivalve speculum and a slight laceration was discovered, healing by granulation. The following morning, the fourteenth day after delivery, the patient was unwell, her temperature was 102°, large doses of quinine were given, but the temperature rose to 103° where it remained with slight morning remission for two days: A more careful examination being made, it was discovered that the uterus was unusually large, that the os was patulous, that there was a foul smelling discharge and considerable abdominal tenderness. The history of the case with these symptoms pointed to the retention of membranes, possibly a portion of the placenta and their subsequent decomposition originated by the admission of air to the vagina and uterus by the use of the speculum. Acting on this diagnosis, the uterine cavity was lightly scraped out with a dull curette and a large quantity of decomposing decidua removed This was followed by an intra-uterine injection of bi-chloride of mercury through a Bozeman's double catheter. The woman's temperature at the time was 103°. The following morning it had sunk to 99°, and within 24 hours was normal, and so remained.

The second case was also a primapara: The labor was terminated by the forceps. Upon the eleventh day the woman, although perfectly well until that time, had a morning temperature of 101° rising in the evening to 102°. The uterus was found larger than it should have been. The os was patulous and there was a fetid discharge. Profiting by the experience gained in the first case the uterus was curetted and a considerable amount of decidua removed, and a intra-uterine douche given. In this case the womb almost at once contracted and the discharge ceased; but the patient had, unfortunately, an exacerbation of a tubercular trouble in one lung which kept the temperature high for some days.

In the third case, also a primapara, after an instrumental labor and an apparently normal lying-in, the temperature rose on the twelfth day to 99.8° and on the following to 100°, at the same time a fetid mucopurulent discharge made its appearance. In this case a very large quantity of decidual membrane was removed and the scraping was repeated on the following day, whereupon the temperature fell to normal and the discharge ceased.

The fourth case was a primapara, who on the sixth day, after an easy labor, had a temperature of 100° although previously there had been no fever; the uterus here was very large, the os quite patulous, but in this case there was not much discharge. The same treatment was employed that had proved successful in the other cases, with the result of reducing the temperature within twenty-four hours to normal, where it remained.

Now this experience is entirely too limited to enable one to come to a definite conclusion as to the cause of late infection in the puerperal state, but these cases suggested to my mind the possibility at least that the retentive and subsequent decomposition of shreds of membrane or fragments of placenta will be found to be the most frequent cause of fever late in the puerperal state, and that if not interfered with this condition may lead to septicæmia and pyæmia. Other causes of fever late in the puerperal state are of course well known. Partially healed wounds of the cervix, vagina and perineum may be torn apart and the fresh wounds thus produced may give entrance to the germs of septicæmia. Exposure to an atmosphere impregnated with emanations from sewers or water-closets from bad sanitation may give rise to febrile diseases at any time during the puerperium as proved in the cases related by Dr. Playfair in a recent English journal. There is a possibility that the pyogenic micro-organisms which may carry on their work in the uterine cavity without very serious consequences to the patient, may in the tubes manufacture their product, pus, in such quantities that it cannot be drained off, thus producing an abscess that may possibly open into the peritoneal cavity. There is a still more remote possibility that a pyo-salpinx may be developed late in the puerperium by other pathogenic micro-organisms, by those of gonorrhœa, of tuberculosis, or even those of actinomycosis. Finally any of the febrile diseases that may attack a woman at any time may fasten themselves upon her during the lying-in period, but, as I have already said, it seems to me that the most common cause of late infection in the puerperal state is the decomposition of retained membrane or fragments of placenta, and that therefore the curette and the intra-uterine douche might be employed as a routine treatment in all cases where there occurs late in the puerperium, fever associated with a large uterus, a patulous os and a foul-smelling discharge. This treatment can do no harm but may effect much good. My own experience in this direction is, however, limited, and upon this point I would like to have the opinion of the Society, whose experience collectively and individually must be greater than my own.

(To be continued.)

FOREIGN CORRESPONDENCE

LETTER FROM LONDON.[1]

Charing Cross Hospital—King's College Hospital—Sir Joseph Lister—The Spray—Sir James Paget—St. Bartholomew's Hospital—Ovariotomy—Antisepsis—Tarsotomy as it should not be done—Museum of the College of Surgeons—Professor Stewart.

Dear Dr. Fenger:—My hospital visits in London began with Charing Cross Hospital. This institution is centrally located and was built in 1837. It contains nearly 200 beds, and affords a fair opportunity for studying accidental surgery, as the majority of cases treated here are recent injuries. Bloxam, Bellamy and Barwell are the surgeons in attendance. Although the spray is still in use and antiseptic dressings are applied, I found many of the wounds suppurating; the best possible proof that the essential and pedantic details of modern treatment of wounds are not fully carried out in practice. Carbolic acid is used as an antiseptic. Frequent changes of dressing undoubtedly are responsible, in many instances, for the numerous failures in securing primary union of wounds. As in most English hospitals, the mechanical treatment of injuries and after resections consists in the use of complicated and ingenious splints which, in the hands of their inventors, answer an admirable purpose in securing rest for the parts and comfort to the patient. Almost every hospital surgeon has immortalized himself by the invention of some kind of a splint, and never tires in pointing out its advantages and the indications for its use. Every London hospital has its own medical school. The building for the school of this hospital is quite small, smaller than any of the college buildings in Chicago, and the material used for illustrating the lectures is entirely inadequate. The class which expects to become proficient in the healing art in this temple of Æsculapius numbers about 200. For a foreigner to visit such a school in the proud city of London it must become evident that science indeed travels westward, when he compares its lecture-rooms with those of the medical colleges in Chicago.

With such reflections I left this hospital and turned my way towards King's College Hospital, where I was to meet the father of antiseptic surgery. I was full of anticipations of what I should see and learn at the feet of the man whose teachings had revolutionized the practice of surgery throughout the entire civilized world. How great my disappointment! A walk through the wards of Sir Joseph Lister soon convinced me that prosperity and honors, even if well deserved, only too often exert an injurious effect upon the scientific career of distinguished professional men. Sir Joseph Lister of to-day is only the shadow of Mr. Joseph Lister of 1876. The dressings which I was shown only corroborate this statement. The only thing that was new to me in the way of dressing wounds was the colored gauze, which is used to distinguish it from gauze not rendered aseptic. Great importance is placed upon the disappear-

[1] By permission of Drs. Fenger and Senn.

ance of color on the surface of the gauze, as an indication that the secretions from the wound have reached the surface, an occurrence which is looked upon as a necessity for a change of dressing. A number of lumbar abscesses were shown which had been simply incised and drained, and where the whole dressing was composed of a very thin and small compress of gauze and a layer of absorbent cotton still smaller than the gauze compress. The tension suture, which has been in general use for more than ten years, was shown and explained as though the hearers had never seen or heard of such a thing.

The German command, *Fort mit dem Spray!* has been obeyed here. The antiseptic solution in use is a combination of corrosive sublimate and muriate of ammonia, which is preferred to the simple solution of sublimate. I am firmly convinced of the fact that had Mr. Lister remained as such in Edinburgh, the scene of his former active life, his scientific existence would not have terminated so abruptly, and many additional discoveries and improvements would have been inscribed upon his tablet of fame. Although his scientific career ended with his change of residence to London, Sir Joseph Lister must be considered as the greatest of living surgeons. The seed that he has sown has brought fruit which has been the means of saving thousands of lives. The principles of antiseptic surgery as taught by him have found the most fertile soil in Germany, where the treatment of wounds has been simplified and improved to such a degree of perfection that primary union is the rule, and the dreaded complications, septicæmia and pyæmia, are almost unknown. Indeed, it must be a great source of satisfaction for Sir Joseph Lister to know that the method of practice he promulgated so strenuously for nearly a decade has been perfected by the most prominent surgeons on the Continent, and that through it the principles and practice of surgery have undergone a complete revolution. It is not my intention to abstract from the greatness of Lister, but I cannot but deplore that for nearly ten years he has been but little else than a spectator in the arena of the surgical world.

Among the most pleasant and profitable hours spent in London I must include a visit to Sir James Paget. Around the breakfast-table we discussed for nearly two hours matters pertaining to surgical interests on both Continents. Any one who has had the pleasure of a personal acquaintance with this gentleman will not wonder any longer why he has by universal consent been the leader among medical men, not only in his own country, but almost the entire world, for nearly half a century. It would be difficult to find a man possessed of so many admirable qualities in the same degree which fit him for such position. A ripe scholar, a clear writer, a model teacher, a successful surgeon, an eloquent speaker, a perfect gentleman, are happy combinations but seldom found in the same person.

He resigned his hospital positions twelve years ago, and is now devoting his whole time to consultation practice and scientific studies. He is inclined to the belief that antiseptic surgery will eventually mean surgical cleanliness. Although advanced in years, his interest in the welfare of his profession reuains unabated and his habits of industry unchanged. He not only reads the literature pertaining to surgery from every possible source, but is likewise perfectly familiar with the recent advancements in the collateral sciences. Through his kindness I found ready entrance into the museums, hospitals and educational institutions of London.

At St. Bartholomew's Hospital I witnessed an ovariotomy by Mr. Langton. This hospital contains about 600 beds, and is connected with a medical school attended by about 350 students. The operation was performed in Martha ward, on the fourth floor, where a small amphitheatre, with room for about twenty spectators, has been built. The room is heated by an open grate fire, and the temperature was not over 70° F. The spray is used during the operation. The patient was 70 years of age and the tumor had been growing for three years. Examination revealed a large cyst in the abdomen, and a number of hard nodules in connection with the cyst could be felt in the pelvis. About fifteen students were present. The usual antiseptic precautions were observed during the operation. The abdomen was opened by an incision through the linea alba about four inches in length, and the cyst tapped with the large trocar of Spencer Wells. The puncture was followed by a free escape of fluid along the sides of the trocar, and some of it entered the abdominal cavity, and the wound was freely irrigated with the cyst contents. Sponges were used to remove the extravasated fluid, and as the cyst collapsed it was drawn out of the wound, an act which was readily accomplished, as no adhesions were found.

It has always seemed to me that the use of a large trocar with a truncated cutting edge in tapping a tense cyst is attended invariably by extravasation of fluid, and consequently increases the risk of peritonitis. When the cyst contents are fluid, the patient should either be placed upon her side during the tapping, and proper precautions adopted to prevent entrance of fluid into the abdominal cavity, or the cyst should be emptied sufficiently to bring it into the wound by the use of a small trocar or by aspiration. In case the contents are colloid they will escape through no tube, and incision of the cyst with the patient upon her side, and traction upon the cyst wall so as to keep it in uninterrupted accurate contact with the abdominal wall, are the only measures which will accomplish the desired object with safety. The pedicle was transfixed with a long-handled needle armed with a double ligature, tied on both sides, cut short and dropped. The peritoneal cavity was sponged out and the abdominal wound closed in the customary manner. The external wound was dusted with iodoform and a typical Lister dressing applied. The dressing proper was fastened upon the abdomen with broad strips of adhesive plaster; over this a cotton compress was applied, retained with a broad flannel bandage. The lower extremities of the patient were covered with a flannel blanket, but no external heat applied. Hæmorrhage, wherever it was discovered, was carefully arrested with hæmostatic forceps and

catgut ligatures. In this hospital all cases of ovariotomy are turned over to Mr. Langton for operation.

In Mr. Savory's wards in this hospital, I was informed by the house surgeon, Mr. Burd, no pretension is made to practise antiseptic surgery, and the resident staff allude with pride to the fact that during the last eleven months only one case of pyæmia occurred, and that the majority of wounds heal without suppuration. Thorough cleanliness in the ordinary sense of the word is enforced, and the wounds are protected with an oiled strip of cloth or covered with a moist compress.

In the operating theatre I found one of the attending surgeons, whose name I do not care to mention, ready to perform tarsotomy in a case of aggravated clubfoot. An incision was made in each side of the tarsus, and after many difficulties and perplexities, a tunnel was made underneath the tendons from one incision to the other, and a chain saw passed through with a probe. Now the difficult task commenced of sawing in the right direction. Two assistants attempted to obey the directions of the operator, but the chain failed to take the proper direction. Disgusted with the performance, the operator took his turn, but utterly failed to correct the insane inclinations of that beastly but determined chain to deviate from the erroneous path. After sawing in multiple directions, the bystanders were assured that one of the incisions of the V had been made, and the chain was slipped towards the ankle-joint and was again set in motion, and after the exertion of a good deal of muscular force, which brought the sweat upon the brows of all immediately concerned in the transaction, it was concluded that the V was made. By this time the operator had become very nervous, and with the forceps made a plunge for the superfluous piece of bone; and after numerous attempts he succeeded in removing a number of fragments.

When an attempt was made to straighten the foot, the disgusted operator convinced himself that more bone must be removed. Instead of using a fine straight saw, or the more modern chisel, he persisted in the use of that rebellious instrument that had already caused so much trouble and anxiety—the chain saw. After another free use of this abominable instrument a few more fragments were removed, and forcible attempt made to bring the foot in proper position. As this could not be accomplished, it was decided that the tendo Achilles was at fault, and this offending structure was handed over to the liberal use of the tenotome. Another forcible attempt to straighten the foot converted the subcutaneous tract into an open wound, and as all the resources had been exhausted by this time, a typical Lister dressing was applied. When Esmarch's constrictor was removed the dressings soon became saturated with crimson blood, which called for more antiseptic material and firmer compression. The surgeon, at this stage of proceedings, was covered with perspiration, and only revived after the patient was carried into the ward and out of sight. I am unable to say what became of the case, but if foot and life were preserved, it is safe to predict that another operation will be required in the future, or London's army of paupers will receive an additional increase.

Nearly a whole day I spent in the Museum of the College of Surgeons, under the kind guidance of Professor Stewart, a distinguished scholar and scientist. By stipulation a number of lectures must be delivered in this institution annually. The present course is given by Prof. Stewart, "On the Comparative Anatomy of the Internal Ear." I had an opportunity to examine the specimens used for illustrating these lectures, and it is safe to claim that no second collection of this kind could be found. A large and valuable library is accessible to all of the members of the college. The Museum contains John Hunter's collection. With this enormous collection as a nucleus, and the liberal donations which have been made by the Fellows and members since its foundation, this museum outranks anything of its kind in the amount of material it contains and the way in which it is classified. The specimens are so arranged that any subject in anatomy, physiology and pathology can be looked up and studied in a remarkably short time with the aid of a complete index, which can be found in its proper place in each section. Almost every subject is illustrated by botanical specimens and specimens of animals, from the lowest to the highest form. Under the head of monstrosities I examined a specimen of a fœtus in fœtu. The fœtus was found in the pelvis of a boy 15 years of age, who died of accidental causes. The fœtus is perfect in every respect, and is surrounded by a thick and dense cyst. The indefatigable energy and great genius of the illustrious founder of this wonderful collection become apparent by the many labels which are marked with his name. N. SENN.

DOMESTIC CORRESPONDENCE

ALBUMINURIA WITHOUT ALBUMIN.

Dear Sir:—I desire to present the following case to the readers of THE JOURNAL, making no attempt to explain their apparently wondrous features. The tests and observations, as well as the records, were made with all possible care and particularity.

Mrs. M., aged 51, American, mother of one child 20 years of age. She presents no special diathesis, but for several years has had a debilitated, and somewhat emaciated appearance resulting chiefly from overwork and a disturbed climacteric. In May, 1886, and during my absence from the city, Mrs. M., from exposure to cold and damp, was attacked with chills and some febrile action, for which my friend, Dr. D. was called to prescribe. Upon my return, about two weeks subsequent to her attack, I found her able to sit up, but presenting the typical pallor of countenance, with puffiness below the eyes characteristic of albuminuria. Dizziness was also complained of, and loss of appetite, with emaciation. The pulse was small, feeble and rapid. The feet, ankles, and legs, nearly to the knees, were tensely œdematous, pitting upon pressure, with the usual glistening of the distended

surface. Inquiry failed to prove any special variation in the color or quantity of the urine at any time since her attack. A specimen was obtained at my first visit, which upon standing threw down a turbid, milky deposit of considerable quantity; color (above sediment) light straw, sp. gr. 1020, heat with and without nitric acid, and nitric acid alone, failed upon repeated trial, to show the presence in any quantity, of albumin.

The microscope more than compensated for this negative chemical testimony by producing sufficient evidence in support of the diagnosis of nephritis. The specimen was marked by the absence of crystals, the field crowded with fat globules and tube casts. The casts were mostly large and roughly fractured; and some contained red blood. Subsequently, up to this date, no less than fifteen careful tests for albumin have been made, and at intervals varying from one week to a month, in some of which I have been assisted by Dr. S. G. Wilson, of this city, the result being uniform in the failure to find albumin. As this report refers only to one, but the most important, characteristic of this condition, the details of treatment are omitted.

The remarkable fact, that we may have albuminuria without albuminous urine receives support in the experience of my friend Dr. Wilson, who has a patient with much anasarca, indeed, water-logged, and whose urine, while loaded with tube casts, resists all attempts to display a trace of albumin, a fact seriously misleading, and actually defeating efforts to arrive at a satisfactory diagnosis or treatment until the tube casts disclosed the situation.

Very truly yours,

H. C. MARKHAM, M.D.

Independence, Iowa, May, 1887.

MISSTATEMENTS OF THE MEDICAL RECORD.

Dear Sir:—One might be led to believe, after reading the following item in the *New York Medical Record*, of May 14, that the editor of that journal is the advisory angel of the American Medical Association:

"The coming meeting of the American Medical Association at Chicago will not, we trust, be 'hippodromed' in the extraordinary and undignified way which characterized its session a year ago. It is not a question of codes, a climate or locality, but of self-respect, the dignity and conservatism which ought to characterize a great representative body of physicians."

It would be well if the editor of the *Record* would attend the meetings of the Association, and learn from personal observation how that body conducts itself, instead of issuing his annual diatribe a thousand miles away, and thus making himself ridiculous by his gross misrepresentations of the conduct of the meetings of the Association and of the large number of physicians who make up that body.

Very truly yours,

J. F. JENKINS, M.D.

Tecumseh, Mich., May 25, 1887.

BOOK REVIEWS.

THE PRINCIPLES AND PRACTICE OF OPERATIVE SURGERY. By STEPHEN SMITH, A.M., M.D., Professor of Clinical Surgery in the University of the City of New York, etc. New and thoroughly revised edition. Illustrated with 1005 woodcuts, 8vo., pp. xxxii—877. Philadelphia: Lea Brothers & Co. 1887. Chicago: A. C. McClurg & Co.

Since the publication of the germ of this work in 1879, there have been eight issues; but this book as it now appears is really the second, and only revised, edition. And one can form but little idea of the change made in the work without directly comparing the first issue with this last edition; the difference lies in the fact that the first edition was the exponent of the operative principles of the "old surgery," while this embodies the principles of the "new surgery."

The first chapter, on the "Civil Obligations of the Surgeon," may seem to be "matter out of place" in a work on operative surgery; but a moment's reflection will show that such is not the case, and it should be carefully read by every medical man. And certainly all must agree with him that "antisepsis imposes new obligations" upon the surgeon; in surgical cases he must apply antiseptic principles with reasonable care and diligence, or he may be justly held responsible for unfavorable results from conditions preventible by antisepsis.

It would be impossible to give an analysis of the book in the short space at our disposal; and, indeed, those familiar with surgical literature will not wish it. Dr. Smith's work does not need our commendation, and, except in a few particulars, it is beyond criticism. The treatment of stricture of the urethra is not mentioned, nor is the operation for shortening bones in extensive injuries to the soft parts.

INTERNATIONAL CONGRESS.

SECTION IN PSYCHOLOGICAL MEDICINE AND NERVOUS DISEASES.

It is proposed to give one of the Sessions of the Section in Psychological Medicine and Nervous Diseases, during the meeting of the Medical Congress, to a discussion on Syphilis and its relations to Insanity.

The discussion will be opened by Dr. George H. Savage, Senior Physician Bethlem Royal Hospital, London, England, and will embrace the following divisions:

1. Iodicy, imbecility, moral perversions due to inherited Syphilis.

2. Insanity associated with acute Syphilis, (*A*) Physical, (*B*) Moral.

3. Syphilis producing Epilepsy, with or without Insanity.

4. Syphilis producing Mental Weakness, (*A*) with, (*B*) without Paralysis.

5. Syphilis as associated with general paralysis of the insane.

6. Pathology, as represented by coarse changes like gummata, or slighter ones as seen in Arterial disease.

Several of our English confrères have already arranged to take part in the above.

Those who intend to engage in the discussion of one or more of the above "questions," should send notice to the Secretary. The time allowed for each paper in the discussion, is ten minutes. Tabular and bibliographical material can appear in the printed paper, but it is respectfully suggested that the matter prepared for reading be as illustrative and pointed as possible.

Clinical observations, post-mortem appearances and conclusions will be specially applicable.

Papers relating to Syphilis and Nervous Diseases will also be read during the same session.

E. D. FERGUSON, *Sec'y.*

Troy, New York.

ASSOCIATION ITEMS.

RAILWAY AND HOTEL RATES.

These rates have been fully published in THE JOURNAL for the past three weeks. The railways have agreed to return physicians attending the meeting, on presentation of a combined certificate and receipt, or simply a receipt from the railroad agent at starting-point, stating that *full* rate has been paid *going* to Chicago. Those who intend coming to the meeting should again read the letter of Dr. Montgomery in THE JOURNAL of May 21, page 586 before setting out.

Dr. Montgomery's instructions in brief are: He will furnish persons starting from points in Trunk Line territory—which is East of Niagara Falls, Buffalo, Salamanca, Pittsburg, Bellaire and Wheeling, with blank forms, known as the "Trunk Line Certificate," upon application to him for same. Persons from the places just named and points West thereof, will be required to use the certificates of the Central Traffic Association, which will be furnished by the ticket agent at starting point when ticket is bought. One or the other of these forms of certificate should be obtained when the ticket is bought for Chicago, as persons living East and South must have their certificates endorsed by the Chairman of the Transportation Committee.

Southern Visitors.—Dr. Montgomery will supply delegates and members of their families, with the "Southern Passenger Association" blank certificate; and such delegates (Southern), will use this certificate upon any of the 42 lines of railway South of the Ohio and Potomac rivers. As regards those living along Trunk Lines or in the Southern Passenger Association territory, Dr. Montgomery's certificates will be honored within territory West of termini of the various trunk lines of roads, as the places named above indicate, as well as to North of the Ohio river—known as the "Central Traffic Association territory."

Tickets for return journey are to be sold in Chicago at one-third the *Lowest Regular Limited Fare*, to those coming from the East or South upon presentation of certificates properly endorsed at the meeting.

In all, there are some ten or twelve members, we believe, that constitute the Committee on Transportation here, whose earnest endeavor it will be, to permit no delay in assisting our professional brethren in the matter of their acquiring full and complete information upon the above topics, at time of arrival, during the stay with us, or before the hour of departure for the return journey. Therefore, we venture a safe prediction in saying, that all who come will be cordially welcomed by this Committee, as well as by the entire profession of this Garden City.

Telegrams for blank certificates will be immediately answered.

MISCELLANEOUS.

MILK AS A MEDIUM OF INFECTION.—The spread of disease through the medium of milk has often been demonstrated, but seldom more strikingly than by an investigation lately pursued by the Massachusetts State Board of Health, for the purpose of discovering the cause of an outbreak of typhoid fever that occurred last autumn in a certain district in Cambridge. It was found that all the milk supplied to the district came from one farm in New Hampshire; that on the farm there was a well into which a privy vault drained, the water of the well being used to wash the milk cans; and, finally, that last summer a person lay sick with typhoid fever on the farm. The conclusion was unavoidable that the fever-germs were carried in the milk, and thus the disease disseminated among the people of Cambridge.—*New York Medical Journal*, March 10, 1887.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM MAY 21, 1887, TO MAY 27, 1887.

Major V. B. Hubbard, Surgeon, granted leave of absence for one month, to take effect on or about June 1, 1887. S. O. 119, A. G. O., May 24, 1887.

Capt. F. W. Elbrey, Asst. Surgeon, found incapacitated for active service by an Army Retiring Board; sick leave still further extended until further orders, on account of disability. S. O. 116, A. G. O., May 20, 1887.

Capt. H. G. Burton, Asst. Surgeon, granted two months' leave of absence, on surgeon's certificate of disability. S. O. 107, Div. Atlantic, May 25, 1887.

OFFICIAL LIST OF CHANGES IN THE MEDICAL CORPS OF THE U. S. NAVY, DURING THE WEEK ENDING MAY 28, 1887.

Deane, C. W., P. A. Surgeon, detached from "Dale," and to hospital, Mare Island.

Harvey, H. P., Surgeon, orders to "Iroquois" revoked, and wait orders.

Dickson, S. H., P. A. Surgeon, detached from Navy Yard, Washington, D. C., and to the "Dale."

Waggener, J. R., Surgeon, detached from the "Iroquois," and wait orders.

White, S. Stuart, Asst. Surgeon, ordered to receiving ship "St. Louis," Navy Yard, League Island.

Field, James G., M.D., of Gordonsville, Va., commissioned Asst. Surgeon in the Navy, May 23, 1887.

OFFICIAL LIST OF CHANGES OF STATIONS AND DUTIES OF MEDICAL OFFICERS OF THE U. S. MARINE HOSPITAL SERVICE FOR THE WEEK ENDED MAY 21, 1887.

Goldsborough. C. B., Surgeon, leave of absence extended to June 1, on account of sickness. May 18, 1887.

Guitéras, John, P. A. Surgeon, granted leave of absence for four days. May 21, 1887.

Armstrong, S. T., P. A. Surgeon, to remain in charge of Service at Memphis, Tenn., until further orders. May 21, 1887.

Bevan, S. C., P. A. Surgeon, leave of absence extended thirty days. May 19, 1887.

Carrington, P. M., Asst. Surgeon, ordered to U. S. Revenue Str. "Rush." May 18, 1887.

Norman, Seaton, Asst. Surgeon, to proceed to Marine Hospital, Baltimore, Md., for temporary duty. May 20, 1887.

Heath, F. C., Asst. Surgeon, granted leave of absence for thirty days. May 18, 1887.

Woodward, R. M., Asst. Surgeon, appointed an Asst. Surgeon May 20, 1887. Assigned to temporary duty at the Marine Hospital, Balttmore, Md. May 21, 1887.